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ABSTRACT

This bibliography was developed to explore the range of therapeutic interventions and innovative strategies and programs used with children and adolescents with emotional problems. The bibliography covers literature published in the 1980s and is divided into five sections: program descriptions (34 entries); treatment strategies (63 entries); evaluation of treatment strategies (15 entries); theory (12 entries); and other (7 entries). Each entry includes a synopsis of the main topic of the article, book, or chapter reviewed; an abstract that describes the content in more detail; and an editorial comment. Author and subject indexes are provided. (JDD)

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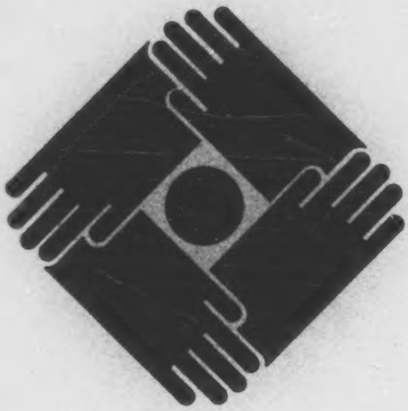
CHOICES FOR TREATMENT: METHODS, MODELS, AND PROGRAMS OF INTERVENTION FOR CHILDREN WITH EMOTIONAL DISABILITIES AND THEIR FAMILIES

An Annotated Bibliography



Therapeutic Case Advocacy Project
Research and Training Center on Family
Support and Children's Mental Health
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CHOICES FOR TREATMENT: METHODS, MODELS, AND PROGRAMS OF INTERVENTION FOR CHILDREN WITH EMOTIONAL DISABILITIES AND THEIR FAMILIES

An Annotated Bibliography

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INTRODUCTION

This bibliography was developed as a part of the Therapeutic Case Advocacy Project to explore the range of therapeutic interventions used with children and adolescents with emotional problems. The literature was limited to that published in the 1980's. In addition to attempting to cover the range of interventions, we also tried to find examples of innovative strategies and programs available to children and their families. In compiling this bibliography we made a special effort to locate relevant research literature; such material is designated by an asterisk (*) preceding the reference.

The bibliography is divided into five sections, each corresponding to the focus of the article or book. In some instances, the focus was not clear-cut, in which case the abstract is in the section that appeared to be the most appropriate.

The items in this bibliography are more than annotations. Each entry includes a *synopsis* of the article, book, or chapter reviewed. These one or two sentences attempt to summarize the main topic of the entry. The synopsis is followed by an *abstract* that describes the content of the article, book or chapter. We have attempted to make these abstracts as inclusive as possible because many readers will not have ready access to the original documents. Each entry ends with a one or two sentence editorial *comment*, which usually defines the audience the author of the entry is addressing.

Content of Chapters

Program Descriptions contains literature about specific treatment programs. In nearly every case the site of the program is identified and the program is described in detail. Some of these entries include an evaluation or research component.

Treatment Strategies contains literature related to types of treatment children and adolescents receive, but are not descriptions of specific programs. For example, this chapter includes articles about behavior modification strategies, psychoanalytical approaches, or cognitive therapies. For the most part, entries in this chapter link the treatment strategies to specific problematic behaviors or diagnoses.

Evaluation includes literature where the principal purpose is to report on research and evaluation of treatment strategies rather than to describe the intervention. This literature often contains some very detailed discussion of research design and methodology.

Theory contains those articles or books that deal with a topic in a comprehensive way. For example, there are entries about residential treatment, the role of families in treatment, or an overview of interventions for specific populations. These articles or books do not focus on one type of program or strategy.

Other is a catch-all section for the literature that could not be categorized into any of the other chapters. This section includes articles related to reviews of the research literature and entries that explore a specific disability in depth.

Index

In addition to categorizing the literature reviewed into these five broad areas, the bibliography has been indexed by areas of interest. Some examples of areas of interest are program level (i.e., residential, day treatment, school based), approach (psychodynamic, behavioral, cognitive), modality (individual, group), population (conduct disorder, affective disorder, autism), age of population, and minority or family issues. The reader can scan the index to identify these areas and then refer to the entries of interest. There is also an author index.

PROGRAM DESCRIPTIONS

Program Descriptions

*Abrahams, L., Court, J. & Phillips, M. (1982). Day treatment for adolescents. *Practice Digest*, 5(3), 23-25.

Synopsis: This article is a description of an adolescent day treatment program that draws on a variety of treatment techniques.

The authors discuss an adolescent day treatment program in Green Bay, Wisconsin, a joint effort of the county mental health center and the city school system. The initial aim of the program was to provide an alternative to out-of-home placements. The two goals of the program are: 1) to keep the adolescent within the family and to help the family learn how to function better; and 2) to return the adolescent to full-time participation at the neighborhood school. The 15 adolescents in the day treatment program attend classes at the Bayview School, which also serves inpatients at the mental health center.

The program lasts into the evening on most days and includes individual counseling, behavioral contracting, peer group counseling, social skills sessions, and family treatment. Social skills classes deal largely with communication, with practice on expressing feelings, assertiveness, and listening. Peer group counseling involves students helping each other solve interpersonal problems. Family counseling can take place either at the center or the student's home and involves contracts that specify home behavior.

A key to the program is a behavior evaluation system that provides immediate feedback to students. The students are rated daily in three areas (school, home, and program) for which they can earn three privileges per day. Rewards include using the canteen, playing games, or guitar lessons, and points can be accumulated to buy goods.

In addition to ratings and points, the program relies on establishing close relationships with students and role modeling skills such as active listening, positive reinforcement, and nonjudgmental criticism. Parents must agree to participate in both family treatment and a seven-week class in communication and parenting skills.

The students remain at Bayview School for about one semester and then gradually wo into a full-day schedule at their community schools. They continue to take part in Bayview's late afternoon, evening and special activities. The whole program usually lasts about one year with another six months or one year follow-up counseling. Workers in the program make use of community resources such as Girl Scouts or Big Brothers. Because return to local schools is the major goal of the day treatment program, weekly progress notes are sent to the local school and appointments with guidance counselors are set up long before the student returns. Inservice training sessions are conducted for school personnel.

Comment: This article, which includes a case vignette, is a description of use of a school located in an inpatient facility and work with community schools.

Adams, D. B. (1980). Adolescent residential treatment: An alternative to institutionalization. *Adolescence, 15*(59), 521-527.

Synopsis: This article is a description of a community-based residential treatment program in Salt Lake City which was established as an alternative to institutionalization.

The program discussed in this article is the Adolescent Residential Treatment and Education Center (ARTEC). Those not admitted to the program are adolescents who exhibit overtly psychotic behaviors, who have mental retardation, who have organic impairments, or those who function well enough to remain in their own homes or in foster care. The major elements of ARTEC are traditional therapy, academics, milieu, and recreational therapy. The therapy is eclectic, utilizing psychoanalytically-oriented individual therapy, transactional analysis, and small groups. A systems approach is used in working with families.

The educational program is geared to the individual strengths of the adolescents. Special education teachers are provided by the local school district. The milieu therapy uses a level system beginning at the orientation level. Both expectations and privileges increase as the adolescent moves from orientation to Level III. After a minimum two weeks of orientation, the resident moves to Level I. At this level behavior, attitude, and conversation are expected to improve. When this occurs, the resident is eligible for home visits, an allowance, and evening activities.

On Level II, adolescents begin to demonstrate leadership by example, providing positive role models for new residents and those at Level I. Those at Level II have an increased allowance, extended home visits, and special activities. Level III includes re-entry and preparation for return to the community. Recreational therapy includes sports and group games as examples of social interaction, both positive and negative.

Goal Attainment Scaling is used to evaluate the program. This technique makes it possible to measure the level of success for several different behaviors. Preliminary results of analysis of the data from Goal Attainment Scaling indicate that behavioral change is possible for adolescents who are acting out.

Comment: This program is unique in that it was instituted to keep adolescents in their local community while providing elements of a traditional residential treatment program.

Program Descriptions

Arbitman-Smith, R. & Haywood, H.C. (1980). Cognitive education for learning-disabled adolescents. *Journal of Abnormal Child Psychology, 8*(1), 51-64.

Synopsis: This article contains a description of an educational program designed to enhance the thinking skills of those with learning disabilities.

Children diagnosed as having learning disabilities perform below age level in academic areas and often evidence poor social performance. Approaches traditionally used when working with this population of students are often not generalizable to other situations. The program described in this article is a cognitive education approach based on the work of Feuerstein and colleagues called Instructional Enrichment (IE). This approach includes basic cognitive operations such as evaluation, interpretation, planning, and comparison. Certain cognitive deficiencies can be found in children with learning disabilities. These include: 1) inability to select relevant versus irrelevant cues in defining a problem; 2) lack or limited use of spontaneous comparative behavior; 3) episodic grasp of reality; 4) blurred and sweeping perception, manifested by lack of clarity, inattentiveness to details, and incompleteness of the perceived data; 5) impulsive, unsystematic exploratory behavior; and 6) lack of, or impaired, verbal tools.

The Instructional Enrichment approach was developed for slow learners. The authors contend that this same approach is helpful for children with learning disabilities because of the similar cognitive deficiencies of both groups. The IE program is organized and structured to teach a variety of problem-solving processes. The procedure includes 15 teaching instruments focused on specific deficient cognitive function. The program covers 250-300 hours of classroom instruction, three to five hours a week spread over at least two years.

This program has been implemented in various cities in the United States. It is now necessary to evaluate these pilot efforts in a sophisticated and detailed way. Preliminary results using control groups indicate that basic cognitive skills can be taught to students labeled learning disabled and these skills can be transferred to new tasks. Of equal interest is the fact that students appear motivated to learn the IE materials and actively participate in class discussion. In many instances, teachers observe positive behavior changes in these students.

Comment: This article does not include a detailed description of the IE program itself but rather a rationale for its use with children with learning disabilities. It would be of interest to those who wish to advocate for cognitive education techniques.

Program Descriptions

Barr, W. & Del Fava, C. (1980). *Public school and community mental health interagency cooperation for treatment of the child with special education needs.* Tacoma, WA: Pierce County Health Department Child Study and Guidance Clinic (ERIC Document Reproduction Service No. ED 201 077).

Synopsis: This paper is a description of a preschool educational day treatment program for children who have serious emotional disabilities.

The program discussed here is a joint effort of public education and community mental health in Tacoma, Washington. The children in the program are deemed to need day treatment as an alternative to hospitalization or out-of-home placement. The program employs a Developmental Therapy model based on stages of development that include: 1) responding to the environment with pleasure; 2) responding to the environment with success; 3) learning skills for successful group participation; 4) investing in the group process; and 5) applying individual/group skills in new situations. Since the areas of development overlap, the curriculum does not delineate activities in isolation. The children need to be active participants in the change process; the materials and activities need to encourage this participation. Classroom structure and rules are important when working with these children. Individual strategies include body contact and touch, removal from the group, physical and verbal redirection, verbal interactions among adults, and reflection and praise.

The Developmental Therapy model uses a set of objectives in four areas -- behavior, socialization, communication, and preacademics. These objectives provide a basis for evaluating progress and for modifying curriculum and strategies. Staff functions are clearly defined to provide a supportive and consistent program for children. Some responsibilities are shared by all team members and include planning the curriculum, providing and coordinating materials, planning the intervention program for the school, home, and community, and providing ongoing in-home intervention.

Parents are involved in the program in various ways. Home visits occur every two weeks to share classroom progress and discuss classroom goals. Classroom observation and parent participation are encouraged. Family and individual therapy are offered but not required.

Comment: This paper is largely a discussion of the partnership between education and mental health and the elements necessary to run such a program.

Program Descriptions

Beitel, A., Everts, P., Boile, B., Nagel, E., Bragdon, C. & MacKesson, B. (1983). Hub Group: An innovative approach to group therapy in a short-term inpatient adolescent unit. *Adolescence*, *24*(69), 1-15.

Synopsis: This article is a description of a group therapy approach to treatment of adolescents with emotional disabilities.

The Hub Group described here began in an Intensive Diagnostic and Treatment Unit (IDTU) created to provide short-term comprehensive diagnostic, educational and treatment services to adolescents. This unit serves 32 adolescents for a minimum of 72 hours and a maximum of 120 days. An individual diagnosis and treatment plan is developed for each adolescent by a multidisciplinary team. In a milieu setting, services include individual, group, and family therapy, therapeutic special education, counseling, rehabilitative services, and psychopharmacological therapy. The IDTU employs a privilege system based on behavioral principles in which the adolescent earns increased freedom and responsibility. The unit includes adolescents with a wide range of psychiatric disabilities; 40-60 percent are adjudicated delinquents.

The staff of the IDTU recognized a need for a mechanism to deal with problems of isolation, lack of positive peer interaction, and ineffective group problem-solving skills. A Hub Group was formed in each living unit to discuss and resolve concerns that arose from the adolescent's experience at the IDTU. The adolescents attend twice weekly 45-minute sessions with co-therapists from a variety of disciplines. These group leaders collaborate closely with other staff.

After three weeks, a group member received a contract, developed in cooperation with the adolescent, which was a description of the adolescent's behavior, interactions, and ways of handling life experiences. Each contract contained two "images"--one positive and one negative. Desirable behaviors were consolidated into a positive image toward which to work. The negative image was a caricature of all the adolescent's negative behaviors. The images were named (i.e., "Lofty Rattlesnake" vs "Blue Ribbon Horse.") The authors state, "By treating each adolescent as special and worthy enough to merit an individual contract which emphasizes his/her uniqueness, therapists encourage active investment in changing. The good image and the bad image stress the fact that he/she can choose how to act." When adolescents adopted their positive images, they were rewarded. Points ranging from 3 (most like positive image) to 1 (most like negative image) were awarded by both group members and by the co-therapists at each session. If the group averaged three points per patient per group session, there was a group reward (pizza or basketball, for example). Every member who averaged three points per session could participate, but those who failed to average three points could not.

Each group varied somewhat from the basic model depending on developmental level of the adolescents and individual preferences of the co-therapists. Some challenges were the fast turnover of group members, group leader "burnout", and acceptance and cooperation of the rest of the staff.

Comment: This article is stimulating and detailed with innovative and imaginative strategies.

Bryngelson, J. (1980, August). *The Yellowstone plan: Individualized education program for emotionally handicapped boys and girls.* Paper presented at a Topical Conference of the Council for Exceptional Children, Minneapolis, MN (ERIC Document Reproduction Service No. ED 195 122).

Synopsis: This paper is a description of an educational program for students who have emotional disabilities.

The Yellowstone Boys and Girls Ranch is a last-chance placement for most of its students. Therefore, the job of the school is to "provide them with skills to survive life." The Ranch is accredited as a psychiatric facility with a full program to meet the needs of each child. This paper specifically concerns the school component of the treatment program, even though, "We see the results of the total milieu as the total program is greater than the sum of its separate parts."

The educational goals for the school are 1) to teach school survival skills and capacities so that each student can achieve success in a less restrictive educational alternative, and 2) to teach life survival skills, attitudes, values, and capacities. Each student has an Individualized Education Plan (I.E.P.); progress is noted by each teacher and discussed by a Child Study Team six to eight times a year. The goal is to mainstream each student. To achieve this goal, the eight self-contained classrooms are arranged in one of four levels from most restrictive to least restrictive. The school is closely coordinated with the treatment milieu of lodge parents, psychotherapists, work program personnel, recreation therapists, and psychiatrists. In addition, each child holds at least one job at the ranch.

The entering student spends 30 days at the ranch assessment center. There is a full-time classroom at this center where the child receives a comprehensive educational evaluation. The psycho-educational assessment determines the content of the I.E.P. The student then enters the program where the curriculum is totally individualized. The social emotional curriculum is based on the proposition that self esteem can be taught through daily prescriptions, classroom meetings, motivational systems, cross-age teaching, tutor programming, and daily school assemblies. Daily academic prescriptions are written for each student. The school also includes a vocational curriculum and a physical education curriculum. Courses are non-graded because a major academic goal is self-directed learning. Behavior and learning are charted which facilitates daily data-based decision making. Students are evaluated daily in each skill area. The school programming includes a motivational system with points earned which may be spent in many ways including a twice-a-month auction.

Staff at the school have conducted inservice training sessions for other educators. The Yellowstone staff believe there are three critical ingredients in their school program. These are 1) the quality of the teachers, 2) an agreed upon mission, and 3) staff knowledge and ability to implement the processes and environment to achieve the mission.

Comment: This paper is a description of the educational component of a treatment program, a part that is rarely discussed in the literature about treatment programs.

Critchley, D.L. & Berlin, I. (1981). Parent participation in milieu treatment of young psychotic children. *American Journal of Orthopsychiatry*, *51*(1), 149-55.

Synopsis: The authors describe parental involvement in a day treatment program for children with psychotic disorders.

Only recently have parents been involved as important participants in day treatment programs. The philosophy of the program described in this article is to "provide maximal therapeutic contacts with children and parents." To ensure a fully integrated program, all milieu staff, including teachers, are involved in working in every aspect of the program.

To counteract staff's adversive impressions of parents, this program includes sustained interactions between parents and staff. The authors feel that "without such involvement, the infrequent contacts between parents and staff are anxiety-provoking to both and often interpreted by each within their existing prejudices and often hostile stereotypes of the other." Most of the parents involved in the program have been blamed by health, mental health and educational professionals (as well as blaming themselves) for their children's problems, regardless of etiological factors. The authors feel that their program has helped reduce these feelings of blame in several ways. Parents have planned weekly participation in the milieu programs which is part of the mutually agreed upon treatment contract. Each parent is assigned to a staff person who acts as a parent liaison. This staff person plans with the rest of the staff regarding the goals and purposes of the individual parent's participation in the program. The liaison provides on-the-spot assistance and support as well as role modeling for interacting with the child.

Initially there was hostility between parents and staff. However, over time staff members began to understand that the parents' behaviors were not based on anger but on helplessness, frustration, inadequacy, and an inability to cope with the child. Staff became more empathic and understanding and began to acknowledge the parents' feelings. It was critical for staff to acknowledge their errors to the parents and to admit they did not have all the answers. Parents responded positively to this approach and identified closely with the treatment efforts. The authors state, "We have come to the conviction that parental participation in the milieu and educational aspects of our program and in family, couple, or individual psychotherapy, depending on the severity of parental disability, is critical to the improvement or recovery of the disturbed child."

Comment: This article is relevant to those working with young children with psychotic disorders and their families. It offers practical and directive advice on how staff can overcome their initial aversion to working with parents.

Devlin, R.J. (1983, April). *A description of an innovative alternative summer school program for emotionally disturbed adolescents in a residential treatment center.* Paper presented at the Conference on Provision of Services to the Severely Emotionally Disturbed and Autistic, Memphis, TN (ERIC Document Reproduction Service No. ED 244 466).

Synopsis: This paper is a description of a summer program for adolescents with emotional problems developed at a residential treatment center.

The program described here was developed at Greenwell Springs Hospital near Baton Rouge, Louisiana. The educational component of this hospital program for adolescents with emotional disabilities is under the jurisdiction of the State Department of Special Education. During the regular school year students have access to a full complement of high school courses, remedial classes, pre-vocational and vocational studies, and functional living classes.

Since the treatment plan for the students requires a 12-month educational program, an alternative program was developed for the summer months to help students reach their academic, social, emotional, and physical potential. The summer program includes exploratory, special interest, and enrichment areas while retaining the functional living class from the regular school year.

The summer courses are not for-credit so academic pressures are lessened. The program emphasizes group interactions and group communication which foster self discipline and functional and practical living skills. Courses offered include one on law and justice, French, journalism (publication of the school newspaper), drug use, basic aspects of camping, gardening, physical education, driver's education, creative writing, consumerism, living skills, career awareness, health, drama, art, math, and computers. Approximately 80 adolescents have participated in the program.

Comment: This paper presents an interesting approach for educational programming in a hospital setting during the summer. There was no evaluation of the program presented in this paper.

Epstein, N. (1982). A residence for autistic and schizophrenic adolescents. *Social Casework*, *63*(4), 209-14.

Synopsis: This article includes a description of a community-based residence for male adolescents and the interventions used to promote eventual semi-independent living.

Hospitalization is an ever-present reality for adolescents with autism or schizophrenia. The common elements of these two disorders are atypical development, high degrees of isolation, inappropriate responses to external stimuli, and without long-term strong interventions, a probable adulthood of institutionalization.

A group therapy program in a community residence was established in New Jersey to provide an alternative to hospitalization for this population of adolescents and to explore the potential of these youth to develop basic skills in communication and appropriate behavior. The adolescents are exposed to a constant repetition of the house rules which included curbing obvious eccentric behaviors, cleaning one's own room, and being responsible for personal hygiene. Treatment is based on modeling and intensive and repetitive teaching of basic living skills. Idiosyncratic behaviors are discouraged while behavior that is appropriate is warmly and highly praised. The family-like setting and tone facilitate the endorsement of appropriate behaviors much like in a parent-child relationship.

Weekly group therapy sessions are intense. They are focused on behavior that could ensure obtaining and retaining employment. This requires constant reinforcement and specific directions. Placement in a job is viewed as the highest achievement sought. Group discussions revolve around issues related to the consequences of bizarre behaviors while working. The group therapy sessions serve as a forum to learn listening skills, sitting still, making eye contact, speaking logically, and so on. Once employed, the residents are supervised and monitored. The employed adolescents meet to discuss how to control bizarre behaviors on the job.

The residents also attend an agency-operated school that provides intensive remedial education with a vocational-functional focus. Much learning takes place in the community--laundries, supermarkets, banks--to teach the adolescents to blend in and learn to cope. The residential program is perceived as being long-term and part of a continuum of a process of life-long care. Without structure and ongoing monitoring, these adolescents would probably regress.

Comment: This author describes one element of a system of care for a population with very serious disabilities.

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Program Descriptions

*Fineberg, B.L., Kettlewell, P.W. & Sowards, S. K. (1982). An evaluation of adolescent inpatient services. *American Journal of Orthopsychiatry, 32*(2), 337-45.

Synopsis: This article is a description of an evaluation of a short-term inpatient program for adolescents.

This study of an inpatient program for adolescents was executed by means of a Target Symptom Scale administered to patients and their parents at admission, discharge, six weeks post-discharge and six months post-discharge. The scale rated the severity of the adolescent's symptoms. The study was conducted in a 12-bed all-adolescent coed inpatient psychiatric program housed in a private general hospital. The average length of stay was nine weeks. Treatment consisted of a three-day per week group therapy, several once-a-week groups that addressed special areas (self-esteem, sexuality, etc.), daily activity and recreational therapies, and two hours a day of school work. Parents attended a weekly parental counseling group and weekly family therapy sessions. Daily visits occurred between patients and parents. The milieu was structured but flexible enough to meet individual needs. The degree of freedom the adolescents received was contingent on their ability to accept responsibilities.

The subjects of this study were 105 adolescents (49 males and 56 females). At admission up to ten target symptoms were selected for each patient. These symptoms were used to construct the Target Symptom Scale for that adolescent. This seven-point scale ranged from "couldn't be a bigger problem" to "not a problem at all." Acting out and affective disturbances were more prevalent symptoms than disordered thinking.

Analysis of the data revealed that there was improvement from admittance to discharge that was maintained for at least six months. Patients felt the program's restrictions were the most helpful aspect of the program. For parents, the weekly parent group was the most helpful. The only complaint made with significant frequency was by parents who felt that they had contact with staff that was too limited. The program did better with adolescents with a prevalence of conduct disorder symptoms. These symptoms appeared to be more responsive to treatment than thought disordered or physical symptoms.

The authors point out the limitations of this study which include the lack of a control group, the lack of analysis of treatment elements, and lack of analysis of which adolescents benefit from which intervention. These issues are being addressed in a two-year study with a control group.

Comment: These authors describe a beginning attempt to refine the field of outcome research of treatment programs for adolescents.

Program Descriptions

*Friedman, R. M., Quick, J., May, J. & Palmer, J. (1983). Social skills training within a day treatment program for emotionally disturbed adolescents. *Child and Youth Services*, 5(4), 139-152.

Synopsis: This articles contains a description of a variety of procedures used to teach social skills within a day treatment program for adolescents who have emotional disabilities.

This article reports on research at a day treatment facility for sixteen boys and girls between twelve and seventeen. Social skills training is emphasized in all features of the program. The program is structured as a school setting with classes in language, math, social skills, leisure skills, physical education, health, and science. Group counseling sessions are held three times a week and individual sessions once a week. The program also includes a point incentive system and weekly family counseling.

Social skills training occurs in structured classes and is practiced in group counseling sessions, "time-in" counseling sessions (short individual counseling sessions that deal with problems as they occur), and "fair fight" procedures (immediate remediation of conflicts between two students). The last two interventions are used to help students learn to solve problems more effectively. The incentive system reinforces proper social behavior, and individual counseling sessions focus on learning social skills when there are major deficits. Family counseling sessions are used to train family members to negotiate with each other and to express feelings and views. Informal interactions between staff and students provide opportunities for modeling appropriate social behavior and reinforce positive progress.

The research reported in this article attempted to determine the changes maintained over time and the generalizability to other settings. The results at a one-year follow-up were encouraging with reductions in foster care placements, temporary shelter placements, and psychiatric placements. There were no commitments to training schools or other delinquency programs. Fifty-four percent of the first twenty-two program graduates spent at least 80 percent of their time constructively involved at one-year follow-up. Because the day treatment program was an integrated one with multiple features, and because skills training was emphasized throughout, it was difficult to determine which specific features contributed to outcomes.

Comment: These authors describe a skills training component and its relationship to the total treatment program.

Goldstein, H., Gabay, D. & Switzer, R. E. (1981). "Fail-Safe" foster family care: A mental hospital-child welfare agency program. *Child Welfare*, *60*(9), 627-636.

Synopsis: This article includes a discussion of the difficulty in discharging children who have been in a psychiatric hospital. One alternative is foster care with treatment backup.

This article is a description of a cooperative program between a child welfare agency and a state hospital for children who have emotional disorders. The program, which took place in Pennsylvania, was an effort to reintegrate children into the community. The hospital selected children appropriate for community living and provided a setting for ongoing psychiatric treatment and monitoring of the care plan. The child welfare agency recruited, interviewed, screened, and selected foster homes, provided ongoing services to the child and parents, and provided intensive support to the foster parents.

Seventy children were processed for foster care placement in a two-year period. They ranged in age from twelve to eighteen years old and had been in the hospital from two to four years. All were considered to have severe emotional disabilities; behaviors included sexual acting out, drug use, physical violence, stealing, undersocialized behavior, and inappropriate language. For one group of children, parents who previously had appeared by and large uninterested "emerged for planning discharge for them rather than permit the child to go into foster care." The process was useful to hospital personnel because "it permitted more intensive work with the child and confirmed that deinstitutionalization was not yet a viable alternative for all children." Several children returned to the hospital after the pretrial period of placement; staff then had the opportunity of working with "fresh reality behaviors" and helped them learn new ways of coping.

Thirty children were actually placed. Of these, twenty were considered successful "since the child made a positive sustained entry into the community, or the placement afforded additional opportunity to develop other appropriate plans for the child." The screening process by hospital personnel after the initial referral was extensive as was the process for selecting foster homes. Group meetings covering a variety of topics were held with foster parents. Once the children were placed, intensive support was provided to the foster families, the children, and the parents.

There were philosophical and style differences between hospital staff and child welfare personnel. Over the course of the project, the concern became the well-being of the child while recognizing rights to disagree. Both the mental health and child welfare systems have strengths to offer; the professional dialogue between the two groups was a refreshing element of the project.

Comment: This article offers practical suggestions and a realistic look at the use of foster family care for children with serious emotional problems.

*Gossett, J.T., Lewis, J.M. & Barnhart, F. D. (1983). *To find a way: The outcome of hospital treatment of disturbed adolescents.* New York: Brunner/Mazel.

Synopsis: This book is about a treatment program in a psychiatric hospital.

The authors describe an outcome study of an inpatient adolescent treatment program. The book includes a literature review of similar studies which reveals: 1) the less the initial disturbance, the better the level of function at followup; 2) "reactive" illnesses have a better prognosis than "process" (acute vs. gradual); 3) below average intelligence is correlated with poor long-term outcome; 4) family variables are not conclusively predictive of outcome; 5) specialized adolescent treatment programs with an educational component have better long-term results than programs incorporated with adults; 6) completion of inpatient treatment relates to successful long-term outcome; and 7) after discharge therapy leads to better long-term outcome. The authors state, "Research data suggest that valuable approaches to innovation would be those that deal directly with the special needs of special groups."

The hospital studied in this book has a psychotherapeutic philosophy, the basic ideology is psychoanalytic although it has a broader systems orientation. Most adolescents in the program have chronic serious disabilities and have had earlier treatment. The most common diagnosis was severe character or personality disorders. The second most prevalent was schizophrenia. A small group had severe and incapacitating phobic or dysthymic disorders.

Three major features of the treatment program were the treatment milieu, the school, and psychotherapies. The treatment milieu included clear communications and flexibility, negotiating decisions, confident optimism, respect, empathy, and capacity to be authoritative if demanded by circumstances. There was a maximum opportunity for positive patient-to-patient influence. The school is committed to the idea that the work of adolescence is education. It includes small (six to ten students) classes taught with empathy and firmness. Individual therapy is provided twice weekly or more and is psychoanalytical in nature. Patients are matched with therapists. There is also a twice a week coed group and daily unit meeting. Family therapy is offered. Interdisciplinary staff meetings are held to share clinical data, formulate or reformulate clinical hypotheses, and plan interventions.

Pilot study results indicate that the severity of psychopathology and type and age of onset of symptomatology are powerful predictors of long-term outcome. Other variables that contribute are high energy level, completion of hospital program, and post-discharge psychotherapy. Some general findings include: 1) the less severe the psychopathology or those with more recent onset do better in a longer-term program; 2) for serious disorders, those who do best are those with antisocial behavior who have subtle signs of guilt and remorse, above average academic ability, and realistic vocational aspirations; 3) there were poorer outcomes with those with chronic personality disorders with antisocial features; and 4) there were poorer outcomes with those with chronic severe schizophrenia who do not improve in adulthood.

Comment: This book includes some valuable information for those making treatment and placement decisions for children with serious emotional problems.

Program Descriptions

*Hawkins, R.P., Meadowcroft, P., Trout, B.A. & Luster, W.C. (1985). Foster family-based treatment. *Journal of Clinical Child Psychology*, *4*(3), 220-228.

Synopsis: This article is a description of a foster family-based treatment program for children and adolescents who are troubled.

The authors describe a program whereby foster parents are selected, trained, supervised and motivated to implement an individual treatment program for a child who is troubled or troubling. The program, part of the services of Pressley Ridge School, a private treatment center in Pittsburgh, is called PRYDE (Pressley Ridge Youth Development Extension). The most unique feature of PRYDE is its emphasis on the parent as the "main agent of treatment" rather than as a caregiver only.

Other features include: 1) parent consultants or supervisors who provide a range of services to the treatment parents and youth; 2) recruitment and training of highly qualified, well-educated parents; 3) emphasis on professionalism of treatment parents by paying them well, providing them preservice and inservice professional training and professional growth opportunities; 4) a high degree of accountability; 5) extensive parent support services such as intensive supervision, respite care, individual youth counseling, liaison services in the community, school, and courts, a 24-hour on-call emergency service, emergency teams for youths in the midst of crisis, and a staffed back-up home for youth who need time away from the PRYDE home; 6) data-based parent and youth performance evaluations on which parent payment increases are dependent; 7) an individualized point-motivation system for each youth in a treatment home; and 8) individual and group services to the biological families.

One professional PRYDE staff, the Parent Supervisor/Community Liaison, coordinates all aspects of each youth's program: training treatment parents, child assessment, child counseling, training and counseling natural parents, and advocacy with schools, court, or community. A normal caseload is seven or eight youths. The PRYDE treatment philosophy is built on a behavior-analysis foundation with an emphasis on motivating people. It includes a token economy or point system.

Most youth involved in the program are referred by child welfare or the juvenile court. Aggressive behaviors are the most common problem; the average age is 13.5 years. Most come from institutional placements and have histories of multiple placements. Parent recruitment required hard work in the beginning. Preservice training for five to fifteen couples with three to five staff members involved ten sessions of 2 1/2 hours each. Topics include social reinforcement, analyzing interactions and their probable effects, active listening, skill teaching, negotiation, time out, reinforcement of incompatible behaviors, relationship building, task analysis, point systems, helping youth make friends, advocating for a youth, stress management, record keeping, emergency medical procedures, and parent evaluation. Each month there is a 2-hour evening inservice workshop.

The results of the program are seen in three measures: 1) discharge status that indicates 82 percent leave for less restrictive environments; 2) follow-ups at six months postdischarge that indicate only one youth re-entered the child welfare or juvenile court systems; and 3) youth satisfaction questionnaires that show that youth rate treatment parents very highly.

Comment: This article includes a detailed description of the program and its advantages and disadvantages.

Hobbs, N. (1983). From demonstration project to nationwide program. *Peabody Journal of Education*, *60*(3), 8-24.

Synopsis: This article is based on a chapter in *The Troubled and Troubling Child*, San Francisco: Jossey Bass, 1982, which describes the history, organization, and program strategies of Project Re-Ed.

Project Re-Ed is an acronym for "a project for the re-education of emotionally disturbed children." It began in the early 1960's at George Peabody College for Teachers at Vanderbilt University. Two ideas are central to Project Re-Ed. First, the role of psychotherapeutic insight as a source of behavior change was questioned. The second idea suggested that "emotional disturbance is a symptom not of individual pathology but of a malfunctioning human ecosystem." The early Project Re-Ed program was funded by monies from the National Institute of Mental Health (NIMH). George Peabody College trained teacher-counselors and ran two pilot projects: Cumberland House Elementary School in Nashville and Wright School in Durham, North Carolina. The teacher-counselors received training in child development, remedial education, behavior management, group-work skills, the use of mental health and educational consultants, arts, crafts, and outdoor skills. Psychologists, social workers, special educators, psychiatrists, and other specialists served as consultants to the teacher-counselors.

The program stresses certain principles: 1) life is to be lived now, not in the past; 2) trust between child and adult is essential; 3) competence makes a difference; 4) time is an ally; 5) self-control can be taught without the development of psychodynamic insight; 6) intelligence can be taught; 7) feelings should be nurtured, shared, controlled when necessary, expressed when too long repressed, and explored with trusted others; 8) the group can be a major source of instruction in growing up; 9) ceremony and ritual give order, stability and confidence to troubled children; 10) the psychological self is constructed around the body or physical self; 11) communities are important to children, but the uses and benefits must be experienced to be learned; and 12) a child should know some joy each day and look forward to some joyous event.

Contrary to some traditional philosophy that a serious disorder must be treated before learning can occur, Project Re-ED believes that the reverse may be true or that at least the process is interactional. Academic competence is important to achieve personal integration and social effectiveness.

The most important idea behind Project Re-Ed is its ecological orientation. "The problem is to be discovered not in the child but in the transactions between the child and the people who play crucial roles in his life." The child is a part of a small social system that includes the family, school, neighborhood, community, and work place. "The goal is to get each member of the system above the minimum behavioral expectations of the other members of the system." Parents are viewed as responsible collaborators and are actively involved in the ongoing program. A liaison teacher-counselor maintains communication with the child's home and regular school. This leads to the concept of preventing placement at a Re-Ed facility, if at all possible, and working with the child and significant others in their natural settings.

Comment: Hobbs' work and that of his colleagues helped form much of the theoretical grounding of Therapeutic Case Advocacy.

Program Descriptions

Isaacs, M.R. & Goldman, S.K. (1985). *Profiles of residential and day treatment programs for seriously emotionally disturbed youth.* Washington, D.C.: Alpha Center.

Synopsis: This book includes profiles of eleven residential and day treatment programs throughout the United States.

There were some characteristics common to all eleven programs profiled: 1) a safe and nurturing environment; 2) a clearly articulated program philosophy; 3) a client-centered focus and did not expect the child to conform to a pre-existing format; 4) individual education programs; 5) clearly articulated disciplinary processes; 6) strong linkages with the community; 7) active and interested boards; 8) a basic approach of establishing relationship with the youth; 9) treatment strategies were eclectic; 10) treatment plans were individualized and regularly revised; 11) group activities were viewed as important; 12) family involvement was considered an essential aspect of treatment; 13) staff communicated with each other; 14) an emphasis on team work and multidisciplinary interaction; 15) a minimization of distinctions between professional and paraprofessional staff; 16) strong staff support; and 17) desirable staff characteristics were a good sense of humor, self-confidence, an ability to share and receive feedback from others, genuineness, flexibility in attitudes and time, a high level of energy, the ability to adapt quickly, positive outlook about oneself and about the youth in the program, and good organizational skills.

Some problems common to all the programs profiled were: 1) need for more day treatment and residential services; 2) instability of funding; 3) lack of some needed services such as aftercare and follow-up, vocational training and rehabilitation services, and research and evaluation; and 4) low staff salaries. A brief description of the eleven programs follow.

1) Advances of Berks County is a private, non-profit day treatment program for adolescents in Reading, Pennsylvania. The treatment program is designed to foster self acceptance and change to increase self-esteem, and teach youth how to deal appropriately with feelings of anger and depression. The program includes individual and group counseling, sports, recreational activities, crafts, educational instruction, and skills development. Staff use a behavior modification approach with a point system. Work with parents occurs in the home.

2) City Lights in Washington, D.C., is a day treatment program for male adolescents of African-American decent. The treatment program is responsive to the needs of youth with a focus on nurturing dependence as a first step toward independence. An eclectic approach to treatment includes both traditional and nontraditional therapies. The program includes an educational component, life skills training, behavioral rewards, recreational activities, and a therapeutic milieu and counseling. City Lights also runs a work-study transition program.

3) Poyama Land is a private, non-profit day treatment program for children three to twelve years old located near Salem, Oregon. The program uses a community-based, multi-disciplinary treatment approach with an emphasis on the family as a unit of intervention. Poyama Land includes an educational program, play groups, social interaction groups, and treatment groups. Children attend their own public school one day per week. Parents must be involved and attend weekly group meetings and are offered individual, group, or family therapy.

4) Alpha Omega, a residential treatment program for adolescent boys located in Littleton, Massachusetts, is a group home with a family-like atmosphere. Residents have both mental health and substance abuse problems. The treatment approach demands that the adolescent assume the burden of change in a nurturing environment. The program includes gestalt therapy, sensitivity groups, T-groups, value clarification and esteem building, recreational, educational, and vocational services. There is heavy family involvement with home visits and group meetings.

5) Children's Village is a private, non-profit residential treatment program for 300 boys (5-14 years at intake) who are neglected and delinquent as well as having an emotional disability. The boys live in cottages and the center includes a recreation center, family center, chapel, store, cafeteria, infirmary, and administrative offices. Treatment includes a program-wide therapeutic community with a broad range of treatment modalities. Children's Village has its own school district with a full range of academic experiences.

6) Lad Lake, Inc. is a private, non-profit residential treatment program for males seven to eighteen years of age located in Dousman, Wisconsin. The program uses an ecological multifaceted treatment approach employing the principles of a continuum of care. The total program includes therapeutic foster homes, a home and community treatment component, an independent living skills unit, and an outpatient psychotherapy clinic. These components, under one agency, add power to the continuum of care concept. The residential treatment program includes a school, recreation program, behavior management system, and individual, group, and family therapy.

7) Whitaker School, in Butner, North Carolina, is a publicly-funded residential treatment center located on the grounds of a state hospital. The school is for adolescents who have a very serious disorder and cannot be treated in any other program. The treatment program is based on the Re-ED principles of Hobbs which includes an ecological approach. Treatment approaches include individual counseling, problem-solving group therapy, and setting up a home/community resource network. Classrooms are in a separate wing of the hospital; major clinical interventions are provided by liaison teacher/counselors and special education teachers.

8) Youth Residential Services in Akron, Ohio, has two residential treatment centers: one for ten adolescents in a group home and one for ten latency aged children on the campus of Andersen Village. The treatment is individualized, family and child focused, and behaviorally oriented. The family must be involved; this is a 5-day program whereby children spend weekends with their families. Children attend neighborhood school in special classrooms.

9) The Regional Institute for Children and Adolescents is a combined day and residential treatment program in Rockville, Maryland with 100 day students and 80 in residential care. The Institute is administered by state mental health and a local school system. Emphasis is on a system-structured behavior management program and mainstreaming and transition to home and community. Parental support and involvement is essential.

10) Spurwink School, in Portland, Maine, is a private non-profit combined day and residential treatment program. Treatment follows a generalist model with one staff responsible for the client and all systems involved with the child. The generalist serves as a therapist, advocate, broker, case manager, and crisis intervenor. The program follows a continuum of care approach with a psychodynamic emphasis.

11) Tri-County Youth Program, Inc., in Northhampton, Massachusetts, is a non-profit, multiple service agency for adolescents. It includes both day and residential treatment components. Treatment approaches are eclectic combining some concepts of their own with the Canadian Psycho-Education model, Bettelheim and Redly's early experiments, some Re-ED concepts, and a reward and punishment system. The clinical orientation is psychodynamic; the program has its own school.

Comment: This book presents a nice variety of programs of special interest to program planners and administrators.

Kennedy, B. (1985). Residential treatment of adolescents: A treatment model. *Canadian Journal of Psychiatry, 30*, 18-21.

Synopsis: This article is a description of a rehabilitation model of residential treatment.

The program described in this article is located in Toronto in an in-patient facility of the C.M. Hincks Treatment Centre. All adolescents in the program have a DSM III defined mental disorder, have failed to function in their natural environment, and many have a history of dangerous behavior. The setting is a sixteen-bed unit for nine boys and seven girls. This unit has a particular interest in concurrent medical disabilities including blindness, deafness, and epilepsy.

The treatment approach is based on the general system theory which believes that social, psychological and biological factors underlying adolescent development are integrated. The approach is psychodynamic whereby the adolescents try to identify past events to understand the meaning of maladaptive behaviors. Treatment is in a highly structured milieu with individualized plans that may include group therapy, family therapy, medication, and behavior modification. The milieu is managed by a treatment team that includes child care workers, teachers, nurses, a social worker and a psychiatrist who serves as the team leader.

The program includes four stages: assessment; stabilization in the unit; stabilization in the community; and aftercare. Assessment occurs during the first four to six weeks and includes a detailed assessment and outlined treatment plan. This plan emphasizes long-term goals in education, occupation, recreation, and family relations. A suitable artificial environment is developed that mirrors the external, natural environment as much as possible.

During the stage of unit stabilization, which lasts two to three months, the milieu is tailored to meet the needs of the adolescent in education, occupation, and recreation. The school program covers an academic program, a vocational program, or a life-skills program. The work program models a small business with marketing, accounting, and the establishment of a cottage industry. The recreational program includes a variety of community and in-house activities such as music, painting, basketball, swimming, and computer games. Family involvement at this stage reflects the recommendations of the assessment stage, but could include family therapy, marital therapy, home visits by members of the treatment team, and family education.

Stage three involves movement into the community using expertise shown on the unit. Some adolescents have difficulty in the community and need close monitoring. This stage of the program is highly supportive and structured. Often the moves are gradual and staff may accompany the adolescent for a time. As the adolescent develops the ability to function in one community setting, others are added. At this stage the adolescents are involved in group therapy.

Once an adolescent is discharged from the inpatient unit, an aftercare worker becomes active. The worker has been involved since intake, but not in an active role. The discharge role of the aftercare worker is to manage community integration, group therapy sessions, and to provide individual and family counseling if indicated.

Comment: This article presents the program in detail which gives a clear picture of the steps in treatment.

Krona, D.A. (1980). Parents as treatment partners in residential care. *Child Welfare*, *59*(2), 91-6.

Synopsis: This article describes a program of using parents as treatment partners in a residential facility.

Current literature indicates that parental involvement is integral in a child's successful treatment. The program described in this article consists of two group homes, each licensed for nine residents, one for males and one for females. The homes are in residential areas and attempt to create a family-like living situation. The treatment approach is behavioral with psychotherapy and family therapy adjuncts.

Parents are involved in the program at intake. They are given copies of records and reports which are explained to them in jargon-free language. Information about the child's functioning, habits, and special interests is elicited from parents. From all the information available, an individual treatment plan is developed by parents and staff. The parents' responsibility and role as treatment partners are fully explained. The author makes it clear that the focus of the discussion is on treatment, not to seek causes or place blame.

Parents are contacted weekly and are sent weekly written reports, which include any disciplinary action taken. Monthly case reviews are held with parents, the staff, and the child to assess progress and problems.

Counseling usually takes place once a week with an individual session with the child and one with the family. The family sessions include training parents in behavior management, communication skills, and contingency contracting. The parents receive homework assignments and outside reading. The agency also schedules parent group meetings to deal with common problems and provide a forum for parents to present ideas and techniques that they have found effective.

Home visits are encouraged. Parents are encouraged to manage problems as best they can and decisions are supported by staff who offer advice and consultation if asked. After home visits, a meeting is held to review any problems and make modifications in the parent training program.

Parents are expected to work with schools on educational programs. Initially, school conferences are attended by both parents and staff. Parents are also involved in discharge planning; in fact they chair the meeting with staff as consultants. The staff are available for consultation for three months following discharge.

Comment: This program goes further than most in involving parents in treatment for their children.

Program Descriptions

Levinson, E.M. (1984). A vocationally oriented secondary school program for the emotionally disturbed. *Vocational Guidance Quarterly*, *33*(1), 76-81.

Synopsis: This article is a description of a vocationally oriented program operated for secondary school students who have an emotional disorder.

The program described in this article was developed by the Southside Special Education Consortium (SSEC) in a rural area of Virginia. In the school setting, students with emotional problems are considered to be employees and the classroom teacher is their supervisor. The program includes a behavior incentive system, academic training, vocational training, work adjustment, and counseling.

The behavior incentive system attempts to replicate the work environment by establishing a hierarchy of worker levels with increasing responsibility, status, and rewards. Students become eligible for promotion from one work level to the next based on supervisor (teacher) evaluations based on work behaviors, effort, task completion, quality of work, and relations with co-workers and supervisor. Weekly "production coefficients" are completed for each student and determine pay and promotion. Students are paid once a week with program currency that can be used to purchase services or goods that are for sale within the program. As a student progresses, benefits include increased pay, vacation and break time, and opportunities for higher status and higher paying jobs with greater responsibility and higher expectations for work performance.

The academic training is individually designed to provide skills that are identified as necessary for success in the particular vocational training program, potential jobs that might be available, and independent living. Basic competencies such as reading, writing, math, and oral communication, are taught within a vocational or independent living context. For example, reading materials provide knowledge of the world of work and requirements and benefits of different jobs.

Vocational training takes place at a vocational technical center located across from the high school. Students are placed based on aptitude, interest, academic competency, and work habits. The vocational education instructor is consulted about the academic and behavioral components of an individual student's program. The work adjustment component of the program provides students with an opportunity to learn and practice occupational social skills and work habits within an actual work setting. The school runs a small cabinet-making business. Students apply and are interviewed for various available jobs that are hierarchically ordered, some paying more than others. Students work during a set period every day and are observed and evaluated on a variety of work habits and occupational social skills. At the end of the week, students are paid (real money taken in through sale of small cabinets and tool boxes) at a rate determined by level, job performed, time worked, and work evaluations.

Students participate in both individual and group counseling, usually on a voluntary basis. Sessions deal with personal, social, or behavioral issues and vocational concerns.

Comment: This author describes a unique twist to behavioral programming using a vocational focus and related to real-life concerns.

Program Descriptions

Lindsay, W.R. (1987). Social skills training with adolescents. In J.C. Coleman (Ed.), *Working with troubled Adolescents* (pp. 107-122). London: Academic Press.

Synopsis: This chapter is a description of a modified approach to social skills training with adolescents.

Lindsay has developed a social skills training program in an unstructured atmosphere, what he terms a "social skills training youth club." Sessions last a whole afternoon or evening and include games that require some social interaction. Initial sessions include getting to know each other and some didactic teaching. The teaching is straightforward with handouts and verbal presentations. Modeling is an integral feature of social skills training and can be organized in various ways. Examples are pre-recorded videotapes or therapist role plays with critiques by the youth. Role play is linked to modeling in that someone would model effective or ineffective behavior in a particular situation. The group would then role play their own responses. Role play is reality-based yet therapist controlled. It allows for practice and can be as short or long, as intense or relaxed, as the therapist deems necessary.

Initially, the therapist may prompt the role players as well as provide cues and reinforcement. The use of cognitive techniques can be helpful to build confidence. The therapist could challenge negative self-statements to make adolescents aware of the statements and thus begin to eliminate them from their thinking.

Lindsay describes a social skills training program he designed for use in a youth club structure. Training begins with discussions of nonverbal communication and non-verbal aspects of speech. Simple role play begins at this time. Training proceeds to the verbal aspects of speech, initiating conversations with both strangers and friends, continuing conversations, and breaking into conversational groups. The therapist summarizes each section as it is completed and also has more formal summary sessions every month or so.

The last sessions are more complex and deal with assertion, keeping out of trouble, dealing with adults and authority figures, interviewing skills, and interaction with members of the opposite sex. The author offers suggestions for various role plays for each of these areas. He feels that social training for adolescents is an area useful to pursue. It is important for therapists to be aware of differences in values between adolescent group members and the therapist. It is also important to ensure that skills learned can be generalized to the adolescents' existing social networks.

Comment: This article is practical and detailed concerning the techniques used to train adolescents in social skills.

*Lovaas, O. I. (1987). Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, *55*(1), 3-9.

Synopsis: This author reports the results of a behavior modification treatment program for young children with autism.

Currently, behavioral interventions with children with autism is thought to be the most promising treatment. Although behavior treatment has shown positive gains in language development and suppression of pathological behaviors, these gains have been specific to a particular environment with substantial relapse at follow-up.

The author's work sought to maximize gains by treating children with autism during most of their waking hours for many years. "Treatment included all significant persons in all significant environments." The project focused on children under 4 years of age as it was assumed that younger children were more likely to generalize their environments and thus maintain gains.

Subjects for the study had to meet three criteria: 1) an independent diagnosis of autism from a medical doctor or a licensed Ph.D. psychologist; 2) a chronological age of less than forty months if mute and less than forty-six months if echolalic; and 3) a prorated mental age of eleven months or more at a chronological age of thirty months. The project took place at the Department of Child Psychiatry, University of California, Los Angeles (UCLA) School of Medicine. Subjects were assigned to either an intensive treatment experimental group or a minimal treatment comparison group. The two groups were comparable at intake.

Each child in the experimental group was assigned several trained student therapists who worked part-time with the child at home, in school, and in the community for an average of forty hours a week for two or more years. Parents were part of the treatment team, were intensively trained in the treatment procedures so that treatment took place during almost all the child's waking hours. The treatment used reinforcement (operant) theory; behavioral deficiencies were targeted and individualized programs developed for each behavior. Aggressive and self-stimulatory behaviors were reduced by being ignored, by use of time out, by shaping an alternative, more acceptable behavior, or as a last resort, by a loud "no" or slap on the thigh.

During the first year, treatment concentrated on reducing self-stimulatory and aggressive behaviors, compliance to elementary verbal requests, teaching imitation, beginning appropriate toy play, and extending treatment into the family. The second year emphasized teaching expressive and early abstract language, interaction with peers and introduction of preschool in the community. The third year concentrated on teaching appropriate expression of emotions, preacademic tasks, and learning by observing other children learn. Children were enrolled whenever possible in a normal (average and public rather than special education) school. The teacher helped carry out the treatment. After preschool placement in public schools were made by school personnel. During kindergarten, children received ten hours or less per week of treatment.

The comparison group received the same kind of treatment but with less intensity (less than ten hours of one-to-one treatment per week), and with no systematic physical aversives. A second control group of twenty-one subjects were followed even though they did not receive the treatment described here. The two comparison groups did not differ significantly at intake.

Of the nineteen children in the experimental group, nine successfully completed normal first grade in a public school and had normal to above normal IQ scores (mean = 107, range 94-120). Eight children passed first grade in aphasia (language-delayed) classes and had IQ scores in the mildly retarded range (mean = 70, range 56-95). Only two children were placed in classes for children who have autism and mental retardation and scored in the profoundly retarded range (less than 30). There were substantial increases in intellectual functioning in the experimental group after treatment (thirty IQ points over control group subjects). The IQ scores of the two control groups remained unchanged between intake and follow-up.

The success of this treatment is impressive. The author points out that replication is not possible without extensive training and experience in one-to-one behavioral treatment. It is also unlikely that treatment effects could be replicated without contingent aversive therapy. It is also very important that treatment begin early and limits generalization of the data to older children with autism.

Comment: This article is a description of one of the most successful treatments of autism. The article is very research oriented.

Mayer, J.E. (1980). Combining psychodynamic and behavioral treatment approaches in the treatment of hospitalized adolescents. *Adolescence, 20*(80), 783-795.

Synopsis: This article includes a description of a treatment program for hospitalized adolescents that combines behavioral/objective techniques with subjective/clinical strategies.

The author describes an adolescent treatment program designed to provide an environment similar to Bruno Bettelheim's Orthogenic School in Chicago. Progression in treatment is made in a series of steps while in a structured setting. The program contains five components: the milieu, individual psychodynamic psychotherapy, education, counseling, and family therapy. It employs a credit system (not a behavior modification system) that is not rigid, objective, or reward/punishment oriented. Rather it is highly subjective, flexible, individualized, focused on patient responsibility, and generalizable to the community outside the hospital. It is principally a method of measurement and documentation with check marks on a tally sheet if expectations and responsibilities are met by the adolescent.

When adolescents enter a hospital program they are in need of behavior management. (If they are not, hospitalization is questionable.) As they progress in the program they begin to deal with intrapsychic issues. The issues of ego control are dealt with through the credit system until the adolescents can develop controls of their own by internalizing the program.

Patients also can earn credits for making therapeutic progress through participation in group therapy and through meeting therapeutic goals established by the patient and staff. Once a specified number of credits are earned, patients receive special privileges. The patients can lose credits by not meeting behavioral expectations or refusing or disrupting therapy sessions.

In this program individual psychotherapy is very important, but is not part of the structured program or the credit system. Each patient receives some form of daily schooling structured by the credit system. A condition for entering the program is that the adolescent's family become involved from the onset.

This article is a description of a program that is just beginning and is termed a "preliminary report." The program was created to meet the demands for structure as well as for insight therapy.

Comment: The program described in this article is unique in its attempt to implement a structured psychodynamic treatment model.

McKelvey, R.S. (1988). A continuum of mental health care for children and adolescents. *Hospital and Community Psychiatry*, *39*(8), 870-873.

Synopsis: This article is a description of a mental health program that offers a continuum of inpatient and outpatient services on one campus.

The author begins by stating, "...providing mental health treatment for children routinely involves discontinuities in care, obstacles to involving the family in treatment, and movement of the child from site to site and from provider to provider." Placement decisions are often based on funding and jurisdictional issues. This article describes a continuum of care for children and adolescents at a multiservice social welfare agency in Houston called Cullen Bayou Place, which includes a a thirty-eight-bed residential treatment program, a partial hospital for ten children, and a large outpatient program. All are located adjacent to one another.

The Cullen Bayou Place is organized on a medical model. Treatment is provided by multidisciplinary teams, usually a child psychiatrist, a master's level therapist, a child care worker, and a representative from the child's school. The child psychiatrist is the team leader in the hospital and residential care settings. Because Cullen Bayou Place is a part of a multiservice agency, it has access to child welfare services such as foster care, shelter care, and home-based therapy. Since 1986, Cullen Bayou Place and the multiservice center have collaborated in the operation of ten therapeutic foster homes. Criteria for admission and for transfers to different components of the program have been established.

When a team decides to transfer a child, the psychiatrist on one team consults informally with the psychiatrist in the program to which the staff would like to transfer the child. If this seems feasible, the multidisciplinary teams of both units meet to review the case. Program-specific criteria are used only if there is no consensus on transfer. The Cullen Bayou Place program is funded by the child's insurance, public monies, and endowments. Because of the nature of the continuum, some transfers within the program are based on funding issues; however, there is more flexibility than in most systems of care.

The author concludes, "Despite difficulties in its implementation and management, Cullen Bayou Place is a model of how a community-based organization may operate a continuum of mental health care for children and adolescents which have high quality, are appropriate, are cost-effective, and are least restrictive."

Comment: This author describes a unique program of combining many elements in a continuum of care at one central location.

*Munson, R.F. & Blincoe, M. M. (1984). Evaluation of a residential treatment center for emotionally disturbed adolescents. *Adolescence*, *19*(74), 253-61.

Synopsis: This article is a description of an evaluation of a residential treatment center for female adolescents who have emotional disorders.

The residential treatment center discussed in this article is located in a midwest city and administered by a female religious order. The adolescents are female, from thirteen to eighteen years of age, and display numerous behavior problems. There are forty girls in the program at any one time living in three separate dormitories.

The highly structured program consists of individual and group therapy, an individualized educational program, and a levels system which awards points for appropriate behavior and takes away points for inappropriate behavior. The dorms range from very structured to one with much more freedom. The level system is tied to the movement between the three dormitories.

The evaluation examined two criteria of effectiveness: success in the community after discharge and positive changes in two test scores administered at admission and release. The tests were the High School Personality Questionnaire and the Jessness Inventory which measures delinquency and personality types. Twenty-one adolescents were studied, all who had completed the program and had been out at least six months.

The responses to the questions related to post-program success indicate positive results in all areas except employment. Given that the mean age of the girls was 17.6, this was not unexpected. These girls also showed significant differences in a positive direction on the two personality tests. Even though the girls had more integrated personalities, tests did not indicate any change in prosocial values.

The authors caution the reader that there was no control group used in the study. They also feel more longitudinal and comparative studies of residential treatment centers is needed.

Comment: This article's unique feature is that it deals exclusively with female adolescents.

No Author (1986). Building interpersonal and academic competence among troubled inner-city youths, City Lights, Washington, D.C. *Hospital and Community Psychiatry, 37*(11), 1154-1156.

Synopsis: This short article is a description of the City Lights day treatment program in Washington, D.C.

City Lights combines classroom instruction with psychosocial therapy for black male teenagers aged twelve to twenty-two who have serious educational and emotional deficits. Most students are wards of the court; many suffer from borderline or antisocial personality disorders, character disorders, or depression. Students are referred from the courts, community mental health centers, social service agencies, parole officers, and schools. Most have had multiple out-of-home placements and have exhausted nearly every other resource. Initially this private, nonprofit agency was funded by private grants and donations, but now is supported mostly by annual contracts with D.C. social services and mental health.

City Lights offers a total therapeutic and educational environment. In the morning students attend three classes--English, independent living, and math. After lunch each homeroom class meets with a teacher and social worker to discuss issues that affect the group. There are then two more academic classes and a P.E. class. The curriculum is the Comprehensive Competencies Program (developed by the Remediation and Training Institute, Washington, D.C.) which is a computer-managed system of lessons using different mediums--paper and pencil, computer, and cassettes.

After an initial assessment an individualized education program is developed. The student works independently at his own pace with teacher guidance and supervision. The goals of the program vary from student to student and range from reunification with their families to entry-level employment and independent living. Extracurricular activities are scheduled regularly and range from field trips to museums to ice skating.

Each student has a case manager who works with the student's family and other professionals involved with the child (lawyer, physician, psychiatrist, parole officer, social worker). Each student participates in weekly individual or group therapy. Some students receive both types of therapy as well as art therapy. The emphasis in therapy is on the here-and-now, on feelings, on decision-making and problem-solving.

Since 1982 when City Lights opened, thirty students have graduated after an average stay of twenty-four months. Only 20 percent have returned to jails or hospitals. There is a 90 percent attendance rate and a voluntary drop-out rate of only 7 percent. There is increased stability within both natural and foster families.

Twenty additional students attend a school-to-work transition program titled Workplace, begun in 1985 with a start-up grant from the U.S. Department of Education. These students attend classes twenty hours per week and work twenty hours. After a sixty-day evaluation, students are placed in jobs and are provided a network of supportive services such as vocational counseling and seminars.

Comment: This article is a straight-forward description of what is considered to be one of the most successful programs for troubled urban youth.

Robinson, C.M. &. Robinson, L.W. (1979). Involving parents in the treatment of behaviorally disordered children. *Clinical Social Work Journal*, *7*(3), 182-193.

Synopsis: This article contains a description of a training model used successfully with parents of children hospitalized in a psychiatric facility.

The authors state that the increasing recognition of the importance of the social environment of children with behavior disorders has led to the need for professionals to be able to analyze the child's environment. This means that professionals must learn how to involve parents, teachers, and others in therapeutic programs for children. This article is a description of one program designed to promote this involvement conducted at Smallwood Center, the children's unit of Moccasin Bend Mental Health Institute in Chattanooga, Tennessee. Staff members attempted to mobilize all significant people in the child's environment. This article deals only with their efforts to involve parents in the treatment of their children with behavior disorders. Parents were usually natural parents but in some cases were other principal caretakers such as foster parents or grandparents.

The authors make it clear that they are not blaming parents for the child's behavior problems. However, they maintain that, "Behavior reinforced during treatment will probably not be maintained if the parents fail to reinforce it." The Smallwood Center offers inpatient care for approximately thirty-three children, aged six through thirteen, who spend weekends with their parents. The length of stay is usually six months to one year. The children are placed in one of three groups depending on age. Each group has its own treatment team, each with a liaison teacher-counselor who is responsible for working with the parents of the children in the group.

Work with parents begins with an initial ecological interview in the home. The main functions of this interview are: 1) to gather information useful in deciding whether the referral is appropriate; 2) to provide the parents and the child with basic information about the program; 3) to prepare parents for their own involvement in the treatment program; 4) to establish rapport and trust; and 5) to observe parent-child interactions.

Parents are expected to attend weekly group meetings conducted by the liaison. During these meetings, parents are introduced to social learning theory with elements of positive reinforcement, modeling, and ignoring. The parents are presented the basics of child management using positive reinforcement, contingent rewards, and ignoring. The liaisons use a variety of techniques including lecturing, group discussion, role-playing, behavior rehearsal, and designing contingent reward systems. The lectures are short and in plain, every-day language presented in a conversational tone.

After the child leaves the program, the liaison continues to have contact with the parents, frequently at first and then gradually tapering off. The liaison is a resource for the parent indefinitely. The program at Smallwood has worked well for parents who are illiterate and with parents who are college educated. The authors conclude that this type of program has wide applicability and can benefit parents whose children do not yet require inpatient care.

Comment: This article is clearly written and offers specific ways to involve parents. The program's strengths are its nonjudgmental and practical approach.

Rosen, P.M., Peterson, L.E. & Walsh, B.W. (1980). A community residence for severely disturbed adolescents: A cognitive-behavioral approach. *Child Welfare*, *59*(1), 15-25.

Synopsis: This article includes a description of a community-based program for adolescents with severe emotional disorders that uses operant, modeling, and cognitive-behavior strategies.

The program described in this article is titled CLEAT (Community Living Education Aiding Teens), which is a family-style, community-based treatment program for teens of both sexes. All residents had at least one previous hospitalization; presenting problems were violent aggression, sexual deviance, psychotic or schizophrenic symptoms, obsessive-compulsive rituals, and depressed, suicidal behavior. At the time of admission to CLEAT, the adolescent had to be stabilized at an acceptable level and have a pre-arranged day program (school, vocational training or employment).

The clinical program includes a combination of operant, modeling, and cognitive-behavior strategies. The authors call the treatment framework a "point-and-level" system which includes five sequential levels through which residents progress. The first three levels uses a point system in areas such as personal hygiene, chore responsibilities, room responsibilities, and getting up and leaving on time. Behaviors unfamiliar to residents are modeled by staff. Points can be exchanged for privileges; unacceptable behaviors lead to point fines. If residents perform unsatisfactorily during a specific time period, they drop back a level.

Level four is titled "monitoring", where the point systems is faded out but is replaced with instructive feedback on performance. After successful completion of this phase, residents advance to level five, which has no points or formal feedback.

The focus of the point system is to establish consistent performance of daily living skills. It also helps in the reduction of problem behaviors. Residents also have individual contracts that specify positive and negative target behaviors. The contracts employ both cognitive and operant strategies. Residents earn points by following the individualized contract.

The authors report that preliminary data seem to indicate that the CLEAT program is a useful model for previously hospitalized adolescents. However, a formal evaluation has not been completed because of the short length of time the program has been in operation, which precludes extensive follow-up.

Comment: This program has a behavioral focus with a system of phasing out the point process. No evaluation information is presented in this article.

Program Descriptions

Schneider, S. (1984). "Therapeutic families" as an extension of residential treatment for adolescents. *Adolescence, 19*(74), 435-445.

Synopsis: This article is a description of one element in a continuum of services--therapeutic foster family care.

This article includes a discussion of a program in Jerusalem, Israel, for students with minimal brain dysfunction, brain damage or injury, psychiatric complications from one of these disorders, or psychiatric problems that do not require intensive residential treatment. The program includes a therapeutic family, education or vocational training, and psychological treatment and guidance. Adolescents are placed with a foster family during the time they are working or studying. They visit their biological family home on weekends and holidays. The students enter a tailor-made program for learning a skill or trade or for taking educational courses toward a degree. The purpose is to enable students to improve their self-image and build esteem. The treatment places an emphasis on education of parents and teachers or work supervisors rather than on psychotherapy. The adolescents are seen at least twice a week--once in the therapeutic family setting or on the job or in school, and once in an outpatient clinic. The program works with the adolescents' natural families on a regular basis. The philosophy is, "Since students remain a part of their family even though they are 'dorming' during the week with another family, it is important to work with the 'natural' family to accommodate the growth that is (will be) taking place."

The therapeutic families are part of the treatment team and are recruited on the basis of their capacity for giving and receiving, their adaptability, reality testing and knowledge base, and their ego-identity and integrity. Schneider feels that an agency should have a network of all possible service modalities from in-patient psychiatric hospitalization through out-patient treatment. In this system, the same therapist follows the child through all parts of the network and movement from one level to another can be handled expeditiously.

Comment: This author reframes the definition of foster family care in a way that emphasizes strengthening the natural family.

Program Descriptions

*Small, R.W. & Schinke, S.P. (1983). Teaching competence in residential group care: Cognitive problem solving and interpersonal skills training with emotionally disturbed preadolescents. *Journal of Social Service Research*, 7(1), 1-16.

Synopsis: This article is a description of an evaluation of a training program conducted at a residential treatment center.

The authors assert that few empirical studies have been reported about the general effectiveness of residential treatment as an intervention. The data that have been collected suggest that environmental factors after (or before) treatment are more powerful determinants of adjustment than treatment variables. Because the recent shift in emphasis to an ecological approach to treatment (and away from the concept of "cure"), programs have been developed to promote competence and skills that can be transferred to community living. The authors describe one attempt at research in this area.

The research project was conducted at a private residential treatment center serving boys of normal intelligence with diagnoses of hyperactivity, impulsivity, extreme acting-out, delinquency, learning difficulties, and minimal neurological dysfunction. The forty-five boys in the study ranged in age from seven to thirteen years; twenty-one lived at the center and twenty-four came for day treatment.

The boys were randomly assigned to one of four conditions: 1) interpersonal cognitive problem solving plus social skills (two six member groups); 2) interpersonal cognitive problem solving alone (two five member groups); 3) discussion sessions (two six member groups); or 4) assessment testing only (eleven boys). The researchers hypothesized the boys in the combined training group would achieve the most positive scores and the test only group would yield the least positive outcome.

The combined groups received six sixty-minute training sessions over a two-week period. The training included demonstrations, practice, and role play of a three-step problem solving method in conjunction with interpersonal communication skills techniques. The "interpersonal cognitive problem solving" only groups also met six times for one hour each but were intentionally not taught nonverbal and verbal communication skills. The discussion group members attended six one hour sessions where they talked about general personal and social problems identified by the group. The test group completed only an assessment. Group leaders were three men and three women with two or more years experience working with youngsters with emotional problems. They received six hours of training and were assigned by a coin-toss.

A series of post-training measurements were administered to all forth-five boys involved in the study. The results indicate that interpersonal cognitive problem solving combined with social skills training was more effective than interpersonal cognitive problem solving alone and both were more effective than discussion and testing only in modifying cognitions associated with problem solving. Even though the authors encourage further research, they conclude, "Present findings are significant as they confirm the feasibility of teaching ecologically specific competence skills to emotionally disturbed children in residential treatment and provide an empirical foundation for further clinical research."

Comment: These authors describe a complex experimental study in fairly technical terms. However, the message that problem-solving skills and behavior can be taught is clear and convincing.

Spinelli, L.A. & Barton, K.S. (1980). Home management services for families with emotionally disturbed children. *Child Welfare*, *59*(1), 43-52.

Synopsis: This article is a description of a Home Management Specialist program to prevent or reduce residential placement.

This article describes a program instituted by the Southern Home for Children in Philadelphia. Because of the staff's commitment to family involvement in treatment and past failures in stimulating parental participation, the Home Management Service for Families with Emotionally Disturbed Children was conceived in 1975. The clientele at the Home were predominantly adolescent, African American, poor, and socially disorganized. In the past, family treatment concentrated on individual and interpersonal psychological problems. This approach did not deal with the problems clients faced on a daily basis.

By utilizing the Home Management Service, certain goals could be achieved: 1) some children initially referred for residential treatment might remain in their own homes while receiving services; 2) children currently in residential treatment programs might return home sooner; and 3) re-placement of children who returned home following residential treatment might be prevented. The authors explain, "The majority of Southern Home families are unable to participate in meetings and activities or in family therapy, not because of 'resistance' to change in a psychological sense, but because of preoccupation with overwhelming subsistence issues."

Home Management Specialists teach, support, and motivate the parents (or caretakers) with whom they work. The focus is to assist others to develop and sustain knowledge and skills that lead to independent, mentally healthy functioning. Each specialist spends approximately three hours per week with each family in the home and community. They help to define life goals, demonstrate and participate in child and household management skills, searching for suitable housing, applying for employment, or meeting staff from other agencies. Home Management Specialists are introduced to every family at the time of the initial evaluation. They also serve as co-therapists in a weekly evening group of new families. The specialists have also helped prepare older adolescents for independent living. An M.S.W. social worker directs the program. The supervisory and line staff (Specialists) are skilled in child and household management and have knowledge of and expertise in using community resources. All are over thirty, have reared children of their own, and most are divorced. Several specialists are parents of children who have had successful treatment for emotional disorders.

Youth counselors have been added to the staff of Home Management Services to act as "male figure" role models and motivators for siblings of the child who has emotional problems. The Home Management Specialists tend to "overidentify" with parents. However, this is balanced by the availability and supervision of a social work practitioner. The specialist is part of the treatment team. They have been used as trainers for the agency's social work staff and staff of other agencies to explain techniques and approaches they have found useful. The authors conclude, "Through their personal characteristics and their variable approaches, Home Management staff members have overcome many of the barriers of mistrust that prevented the most disturbed families from using the help available through the agency."

Comment: This article is relevant to many issues: family supports, "resistive" parents, informal supports, and working with minority families.

Steinberg, D. (1987). Innovation in an adolescent unit: The introduction of small group work. In J.C. Coleman (Ed.), *Working With troubled adolescents* (pp. 79-90). London: Academic Press.

Synopsis: This chapter is a description of the introduction of small group work to a well-established adolescent unit in a larger hospital.

The unit described in this chapter consists of two wards--one for boys and one for girls--located in a psychiatric hospital in England. The primary purpose of the unit was to provide a general psychiatric service with an eclectic range of treatments and patients. Before the introduction of small groups, the emphasis was on individual work with adolescents and separate work with parents.

A strong reason for instituting organized small groups was that some informal small group activities were already a part of the social environment; organizing could facilitate looking at these activities and evaluating them. Another reason for introducing group work was to make the adolescents feel less vulnerable and uncomfortable than some were in individual therapy alone. The author adds, "The small groups and their supervision were set up as, among other things, a bridge between expert 'psychotherapy' and the important, demanding but less intensively supervised day-to-day transference of feelings between staff and patients." The central principle was to provide a safe way for boys and girls who have emotional disorders to gain basic skills in interpersonal relationships. The groups had goals for both the group as a whole and for individuals within them.

The groups included five or six children and three staff; they met once a week for forty-five minutes followed by fifteen minutes for the staff alone. Once a week, staff met in a supervision group to explore feelings and to observe similarities and differences between groups. Every six weeks all staff involved with groups met for joint planning and an exchange of ideas and teaching.

An evaluation of the small group program is in the pilot phase. The desire is to test the hypothesis that changes in individual behavior in the group would predict changes in other relationships in the unit and outside. It is clear that the groups have done no harm and individual improvement has occurred. Staff have become enthusiastic about the groups after some initial doubts and resistance. All levels of staff, including nurses, are involved which has led to various program initiatives from all staff levels. The author concludes, "We have no proof that the groups 'work' in the sense that would satisfy most scientific enquirers...For the unit, the groups have provided a valuable focus for staff training and development."

Comment: This chapter presents a clear picture of the process of establishing small groups into an existing program.

Stetson, F.H. & Rhead, J.C. (1985). *A Conceptual Framework for Providing Services to Seriously Emotionally Disturbed Children and Adolescents* (ERIC Document Reproduction No. 148 628).

Synopsis: This article is a description of a milieu treatment focus in a day and residential treatment program for children who have serious emotional disorders.

The Regional Institute for Children and Adolescents (RICA)-Cheltenham Center, located in Prince George County, Maryland, was developed as a public interagency program to provide education and mental health services to children and adolescents with emotional problems. The program serves seventy-five students, both male and female, covering all ages up to eighteen years. Twenty students are in the residential program and the remainder in day treatment. Most of the students have major mood and thought disorders. Conduct disorders and/or drug abuse alone are not criteria for admission.

Upon admission a student is assigned to one of three multi-disciplinary teams depending on grade level. The educational component provides individualized special education services that include a mainstream program for reintegration into a less restrictive educational program. The mental health component provides individual, group, and family therapy. The residential component provides a structured living environment to aid the development of skills in interpersonal communication and problem solving. Representatives of these components formulate and implement treatment plans.

The RICA program has five concepts that are implemented in the day-to-day functioning of the program. The first is *positive expectations*, whereby a strong emphasis is placed on the best a child has to offer, where an optimistic attitude is maintained, and positive attributes and potentials are identified. The second concept is the *circle of adults*, which includes parents, relatives, neighbors, representatives of various social agencies, private therapists, and any other adults involved in the student's life in a caring way. A cooperative effort on the part of all the adults is encouraged at every opportunity. The third concept is *respect for the family unit*, which is viewed as the primary social unit. Emphasis is placed on the authority of the parents over their children and the significance of the family is continuously acknowledged. Parents participate in planning meetings, suspension conferences, and any other meetings where important decisions are made.

The next concept involves *responsibilities and choices*, both in regard to the child and to the parents. The students are involved in a behavior management level system that is designed to monitor behavior and provide appropriate consequences for both positive and negative behavior. Day treatment program students also have their behavior monitored at home. The last concept of the program is *continuity, consistency, and flexibility*. Continuity and consistency are helpful in building a sense of security. Flexibility is necessary for decision-making and setting an example to students of adaptive behavior.

The authors state, "Through the communication of these concepts the program attempts to positively impact students and their families and to aid them to take charge of their lives, make appropriate choices, and to achieve the success they desire."

Comment: This article presents a detailed philosophy and description of a program unique because of its strong family emphasis and positive approach to treatment.

Tomalesky, M. & Jackson, R. (1985). The safety harbor exceptional student center: Multiphasic academic/therapeutic program model. *Research in Education*, February (ERIC Document Reproduction Service No. ED 248 630).

Synopsis: This article is a discussion of a program model for children with severe emotional disabilities who are unable to function within a mainstream program for children who have emotional disorders.

The model described here was developed in Pinnellas County, Florida, for children whose disabilities are sufficient to preclude mainstreaming activities and for whom placement in a special center is necessary to meet the student's needs. Titled the Safety Harbor Exceptional Student Center, the program is based on several assumptions: 1) success in school has a high positive correlation with success in society; 2) most students who have severe emotional disorders can be returned to mainstream school programs; and 3) the majority of these students are capable of learning appropriate self-control skills.

The center program includes both individual student goals and center program goals to help students reach their personal goals. Goals for the student include: 1) adapt to school environment; 2) develop self-control skills; 3) develop emotional awareness; 4) develop appropriate emotional/social skills; 5) expand/develop academic skills; and 6) demonstrate the previous five goals and mainstream. Goals for the program are: 1) maintain a consistent, fair, therapeutic environment; 2) provide trained change agents; 3) provide therapeutic intervention; 4) provide therapeutic emotional growth experiences; 5) provide academic curriculum; 6) provide for family and community involvement; and 7) follow-up cases.

The program model is divided into six sequential phases, each designed to join with the preceding phase to build the whole program. The first phase is to provide a behavior management system that has four major subparts: a) a token system; b) a response cost system; c) a level system; and d) a separate room as an alternative to the regular classroom for students to act out and process emotions with an adult.

The second phase is affective intervention to reduce crises by allowing teachers to develop a positive rapport with each student using emotive counseling techniques. Phase three deals with the academic curriculum based on individual needs and skills to develop cognitive and academic competence. This phase includes a skill development and vocational component for middle and high school grade students.

Phase four, therapeutic intervention, is to provide group and individual counseling for each student, directed toward expanding awareness of emotional processes and development. No long-term psychotherapy takes place. The goal of the fifth phase, therapeutic curriculum, is to enhance the social and emotional skills through affective education led by a guidance counselor. The last phase deals with special resources such as psychiatric consultation, case follow-up,, and parent involvement.

The authors feel that a unique feature of the program is that staff are willing to take risks along with the students. The Safety Harbor program is "constantly undergoing modification to better achieve its objectives."

Comment: This article is very specific and detailed; it is relevant to special educators. There is no evaluation component described in the article.

Williams, R. (1982). The ED primary student: An approach that works. *Academic Therapy, 18*(2), 217-23.

Synopsis: This article reports on a program for primary-age students who have emotional disorders; it is called the Cavendish program in England.

The Cavendish School operates as a special education institution to serve children seven to twelve years of age who have severe disorders. The school contains six classrooms, three offices, and a cafeteria/gym. There are a maximum of thirty-two students at the school at any one time. They have been referred for aggressive or violent acts, disobedience, spitting or flaunting authority, vandalism, inability to concentrate or complete work, and expulsion from regular school. Primary staff are a headmistress and four special education teachers. Also on staff are a play specialist or a combination of recreation therapist and a physical education teacher, an art therapist, six teacher's aides, two half-time social workers, a psychiatric consultant, a one-fourth time speech therapist, a gardener, and a cook.

The schedule offers two half-hour academic periods, one in the morning and one in the afternoon. The rest of the day consists of activities such as play, recess, or lunch. Rooms vary in degree of structuring from a relatively unstructured science room to a very structured room with a cooking center. There is great flexibility of movement between classrooms and choices offered during activity periods. There is a daily meeting at 10:30 a.m. that all students attend. Good behavior is praised and all school rules are made by staff and children. A special meeting can be called by anyone at any time. There is also a "court" with four judges elected each term. The court meets twice a week to hear conflicts and settle disputes. Students intervene to settle altercations.

The goal of the program is for children to return to their regular classrooms. Staff encourages students to accept responsibility for personal choices. Transition back to regular school can take months, beginning with mornings only. The student makes the decision about how long to remain in the afternoons.

Approximately half of the day is devoted to physical activities. The social workers spend a considerable amount of time with parents in their homes. The unique features of this program are the separate nature of the school, a full staff, immediate response to crisis, daily meetings, the use of the "court," and the use of play, games, and sports as integral parts of the students' behavioral and social education.

Comment: The author believes American schools should use play and games for their value in the art of living and learning with others.

TREATMENT STRATEGIES

Treatment Strategies

Awad, G. A. (1983). The middle phase of psychotherapy with antisocial adolescents. *American Journal of Psychotherapy, 37*(2), 190-201.

Synopsis: This article is a discussion of the frustrations of psychotherapy with adolescents who are antisocial. The author suggests ways of making the treatment experience more gratifying.

Working with adolescents in psychotherapy is often thought of as a deviation from "pure" psychoanalysis. The author, a psychiatrist and psychoanalyst, debunks this notion. "Psychoanalytic techniques that developed with adult neurotic patients cannot be applied to adolescents. It is more useful to develop techniques in response to the adolescent's dynamics and functioning, instead of calling them modification or paradigms...We should try to find the technique that would produce the best results most efficiently."

The patients discussed here are adolescents who have behavioral and antisocial problems, usually with school and family difficulties. The middle phase of therapy is when the focus is on change, and the therapist has been able to engage and earn the trust of the adolescent. When treating adolescents, it is important to establish a balance between free association, regression and transference on the one hand and dealing with practical issues (school, police, parents) on the other. This balance requires that the therapist take both passive and active roles depending on the situations of the individual adolescents and changes in their lives. The author states, "There has to be a balance, whereby the regressive aspect of the relationship should be paramount, while the management aspect should be kept at a minimum and should be monitored as to how it influences the therapeutic relationship."

In sessions the therapist should ask open-ended questions and should not set agendas but follow the clues of the patient. The more the therapist understands the dynamics of a particular adolescent, the more this information can help determine interventions. In general, the therapist must try to keep the verbal interaction moving and responsive to what the adolescent needs. The therapist needs to be supportive (rather than interpretive) and perform an educational function if the family doesn't or can't.

In the process of treatment, the therapist intervenes in various ways. *Listening* involves more than just hearing and understanding what the adolescent is saying. It includes understanding unconscious communication; any material can be explored without fear or shame. *Clarifications* consist of asking questions to clarify issues and reduce the client's anxiety. *Confrontations* involve bringing the adolescent's attention to feelings and behaviors that are being ignored. *Suggestions* should be presented as options and directed toward issues that the adolescent really wants. *Interpretations*, or the uncovering of unconscious material, vary with the phase of treatment. They do not play as important a role in work with adolescents as they do in adult therapy and are used most frequently in the middle phase.

Comment: This article is written for those involved in individual psychotherapy with adolescents, especially those who use psychoanalytical approaches. It is detailed and specific and includes case vignettes.

Treatment Strategies

Baker, P.K.S. (1984). A comprehensive model of practice for borderline adolescents. *Clinical Social Work Journal*, *12*(2), 320-331.

Synopsis: This article is a description of a psychosocial model of treatment for use with borderline adolescents.

The author has developed a practice model intended for use in a day or residential treatment center that includes a school and a vocational training component. The clients are adolescents with borderline personality disorders and their families. The approach is based on ecosystems theory, object relations theory, and the theory of structural family therapy.

Ecosystems theory is "concerned with the growth, development, and potentialities of human beings and with the properties of the environment that support (or fail to support) that growth and development." Some of the concepts of this perspective are: 1) adaptation--the fit between the individual and the environment; 2) autonomy--the degree of freedom from the environment and psychologically from inner and outer pressure; 3) competence--a sense of mastery of the inner life of feelings and impulses and of the environment; 4) relatedness--the ability to care for and be cared for; and 5) a sense of identity--a feeling of self arising out of human relatedness. Because an adolescent who is borderline is fixated at an early childhood stage, these conceptual states have not been attained. Treatment must address these concepts to be successful. This can be accomplished in a school setting with individual attention and planning and behavior monitoring combined with after-school job opportunities.

Individual therapy with the adolescent can be either insight oriented or supportive depending on the child's ego strength and contact with reality. Insight-oriented techniques should not be used with more fragile adolescents who lose touch with reality. Therapy includes limit-setting, support, confrontation about inappropriate defenses and behavior, empathy, and interpretation of the linkage of behavior to feelings. The individual therapy is integrated with work with the family and school in support of the adolescent's ability to separate and become autonomous.

Structured family therapy is an integral component of this model. The author suggests the use of cotherapists to minimize over identification with or resistance to one therapist. The goals of the therapy are determined by the family and therapists together and may change as therapy progresses.

Because work with these adolescents and their families is emotionally involving and draining, the author suggests that support groups for all staff are important to avoid splits between staff members.

Baker feels that this social work practice model broadens treatment from purely intrapsychic factors to include environmental adjustments.

Comment: This article incorporates some of the principles of Therapeutic Case Advocacy, including environmental concerns and family involvement.

Treatment Strategies

Barton, B. R., Jr. & Martin-Days, C. (1982). Adolescent depression: Significant issues in diagnosis and treatment of constricted adolescents. *Clinical Social Work Journal, 10*(4), 275-88.

Synopsis: This article is an examination of depression in adolescents who are constricted emotionally and describes two therapeutic styles of treatment in two case illustrations.

Symptoms of depression in adolescents who are emotionally constricted are sadness, loneliness, feelings of isolation, feelings of being unwanted, and passivity. As children these adolescents appeared happy and easygoing, perhaps concealing their unhappiness. Treatment techniques differ for these adolescents from those used with more oppositional, acting-out adolescents with depression. The authors feel that adolescents with depression have experienced real or fantasized traumatic losses that "prevent the youngster from synthesizing and integrating experiences into a concept of self that is more progressive than regressive."

It is important that adolescents with depression share their feelings with the therapist. Some adolescents are resistant to any therapy that requires verbalization. The therapist needs to encourage the use of words and tune into and speak about feelings if verbal feedback is not forthcoming. Most therapists believe that interventions with these adolescents should be long-term rather than crisis oriented. Family involvement is crucial in work with adolescents with depression.

The bulk of this article is a description of work with two adolescents who were depressed and constricted emotionally. The therapists spent much time developing a trusting relationship with the adolescents. In the first instance, the child was in residential treatment; the therapist used the opportunity to interact with the adolescent on an informal basis as well as in therapy sessions. The therapist became the one significant person who could effect the grieving process that led to self-identification.

Comment: This article is very clinical; however, it could be helpful to those working with this specific population of adolescents.

Blom, S. D., Lininger, R.S. & Charlesworth, W.R. (1987). Ecological observation of emotionally and behaviorally disordered students: An alternative method. *American Journal of Orthopsychiatry*, 57(1), 49-59.

Synopsis: This article is a description of an ecological approach, called Problem Behavior Analysis (PORBA), to the assessment of students who have emotional and behavioral disorders and their educational environments. The article includes case examples.

Even though the use of ecological assessment with students who have emotional and behavioral disorders recently has been encouraged, few specific suggestions on how to do this exist. The lack of specificity about how to conduct an ecological assessment and the continued use of traditional procedures suggest confusion as to what constitutes such an approach. The authors attempt to define an ecological approach to assessment and describe a specific observational method for assessing child and environment interactions which they call Problem Behavior Analysis (PROBA).

An ecological perspective on emotional disorders maintains that the disabling condition is the result of the interaction between the child and the environment. Problems reside in the mismatch between the two. Hobbs is the best known of the proponents of the ecological approach to behavior disorders but did not focus his work on diagnosis and assessment. Bronfenbrenner and Swap, et al. have provided some conceptual framework to conducting ecological assessment. The authors combine Hobb's philosophy with Bronfenbrenner and Swap, et al.'s levels of assessment to define ecological assessment as "a description of the match or mismatch between a child and the child's environment on three levels." The first level is observation of behavior-environment transaction in given situations; the second is a comparison of interactions in multiple settings; and the third is an analysis of whether the transactions in multiple settings are deviant enough to label the child emotionally or behaviorally disordered.

Because one of the most important uses of an assessment is to formulate an Individualized Education Plan (IEP), an assessment based on environment-behavior observations can produce an IEP written for both the child and for others in the child's environment. Problem Behavior Analysis has been pilot tested in several public schools in rural areas of a midwestern state. PROBA is oriented toward adaptive rather than maladaptive behaviors and transactions. A variety of everyday problems are defined and a response recorded along with the consequences of the response. In addition the students are observed in non-problem solving situations for periods of thirty to forty minutes. The responses of the target child are compared to those of control peers. The extent of the discrepancy from peers in observed areas becomes the basis for IEP objectives as well as a baseline for recording progress over time. The PROBA also uncovers positive interactions and responses which can help in making classroom placement decisions.

This type of ecological observation for assessments is time-consuming. However, the authors argue that observation is necessary to understand interactions between a child and the child's environment.

Comment: This article is complex and education-oriented and is relevant to those dealing with environmental issues.

Treatment Strategies

*Bornstein, M., Bellack, A.S. & Hersen, M. (1980). Social skills training for highly aggressive children. *Behavior Modification*, *4*(2), 173-186.

Synopsis: This article is a description of a study of the effectiveness of social skills training on children who are highly aggressive and in treatment in an inpatient psychiatric setting.

Social skills training has been reported to be successful with aggressive adults, but the utility of these procedures with children who have severe disorders and highly aggressive has not been determined. The authors describe a study that is a first step toward examination of social skills training for this type of child. The subjects were four children of an inpatient psychiatric facility in Pittsburgh. Children were selected because they were identified as overly aggressive and had inappropriate interpersonal behaviors. The group included two boys and two girls age eight to twelve.

The training consisted of an interpersonal situation presented by the therapist. Role models (in this case graduate students) delivered a prompt to which the child responded. The therapist then provided feedback to the child with reference to a specific target behavior. The child and the therapist discussed the feedback, and then the role model and the child continued to rehearse the situation. When the therapist was satisfied that the criteria for the target behavior had been reached, the training advanced to a new interpersonal situation. Children were exposed to three fifteen to thirty minute sessions of social skills training per target behavior. The sessions were videotaped as were regular ward group sessions.

The videotapes were viewed by raters for eye contact, overall assertiveness, smiles, hostile tones and requests. The children were taped and rated in their therapy group approximately twenty-six weeks after social skills training was completed. The authors state that the results are open to different interpretations depending on one's perspective. There were substantial improvements on each component behavior and overall assertiveness for each subject. The effects were generally well maintained for periods of up to six months for three of the four children. However, the results for generalization of treatment effects was not as consistently positive. The authors contend that perhaps the most relevant result is the high degree of variability in the children's response to treatment even though they all had similar psychiatric diagnoses and behavioral analyses. This points to the need for careful individualized assessment and treatment strategy.

Comment: This article is a description of a small study with only four children, but the conclusions are thought provoking.

*Brendtro, L. K. & Ness, A.E. (1982). Perspectives on peer group treatment: The use and abuse of guided group interaction/positive peer culture. *Children and Youth Services Review, 4*, 307-324.

Synopsis: This article is a description of an attempt to explore the positive and negative features of guided group interaction.

Guided group interaction or positive peer culture treatment was developed largely outside the traditional clinical professions. This form of treatment has been widely criticized by many professionals. Nonetheless, guided peer group methods are widely used to address juvenile problems. This approach originated in correctional settings but is now found in the full range of youth-serving organizations.

The authors conducted a study of experiences and perceptions of participants in guided group interaction programs through interviews with both staff and youth. The study was intended to be exploratory. Ten programs were identified, two from each of five settings: public schools, alternative schools, community group homes, private residential treatment centers, and public juvenile correctional institutions. Adolescents involved in these programs ranged in age from thirteen to seventeen, were both male and female, and presented a wide range of problems in home, school, and community.

Staff identified ten potential areas for misuse of peer group methodology. In order of expressed concern these were: 1) abuse of confrontation; 2) mechanical verbalizations; 3) family estrangement; 4) poor listening skills; 5) lack of individualization; 6) distant staff relationships; 7) staff abuse of control; 8) inadequate professional training; 9) group leader superiority; and 10) others. Staff were concerned about the groups forcing openness by becoming hostile. All programs reported shifting away from intense confrontation to teaching adolescents to confront with greater empathy and sensitivity. Guided group interaction programs often use a common-sense list of ten or twelve basic problem areas to establish a common basis of understanding between students and staff. These common labels often become a substitute for action.

Youth tended to be enthusiastic and reluctant to criticize their program. However, some themes emerged: 1) the need for privacy and time to think; 2) frustration with being expected to express feelings fully and honestly at all times; 3) problem trivialization in residential settings especially; 4) objections to staff-imposed group restrictions; and 5) some lack of sensitivity to needs for parental contact.

The contributions by staff and students were concrete and pragmatic. All misapplications of peer group treatment had been noted and resolved by some of the programs. The authors offer the following recommendations for operating quality peer group programs: 1) replace peer coercion with peer concern; 2) establish authentic communication; 3) build positive staff relationships; 4) provide private time and space; 5) involve the family; and 6) develop total professional competence. They conclude, "Because peer group approaches offer such great potential for improving youth-serving organizations, it is essential that practitioners of this methodology be committed to searching for creative ways of improving the quality of these programs."

Comment: This article is a useful and informative critique of a currently popular treatment strategy.

Cameron, M.I. & Robinson, V.M.J. (1980). Effects of cognitive training on academic and one-task behavior of hyperactive children. *Journal of Abnormal Child Psychology, 8*(3), 405-419.

Synopsis: This article is a description of a training program in both self-instructional and self-management skills used with children who are hyperactive.

Children who are hyperactive perform less efficiently than others on three aspects of tasks related to attention: 1) selecting appropriate stimuli from a variety of competing stimuli; 2) attending to task-relevant information; and 3) maintaining attention over time. Training programs for these children show improvement on tests of cognitive impulsivity and visual discrimination but seldom generalize to academic or social behaviors. The study described in this article attempted to remedy the shortcomings of previous work by a) incorporating both visual-perceptual tasks and academic (in this case, math) activities into a cognitive training program, and b) teaching children how to apply both self-instructional and self-management strategies to these tasks.

The study took place in a classroom for the behaviorally disordered in New Zealand. Three children with a diagnosis of hyperactivity were selected for the study. Baseline measures were obtained on the children involved in the study through observer ratings, math worksheets, and tape recordings of oral reading.

The training used an individual approach and included 1) training in self-instruction strategies and 2) training in monitoring and self reinforcement of math performance. There were twelve half-hour sessions, five per week. During the self-instructional phase of the training, children were taught to select appropriate stimuli from various alternatives. Originally the skills were taught using block and peg designs, matching visual discrimination tasks, sequence pictures, and memory games. The children were then taught to apply these skills to math problems. The students learned to monitor their own math performance and chart their progress. Points were awarded for following instructions and for correct math answers. In the final phase of the experiment, the children received no training or rewards, but their performance was still monitored.

An analysis of the results of the training showed significant increases in on-task behavior of two of the three children. Significant gains occurred in math accuracy for all three children. The goal of this study was to design a training program that would promote generalization to classroom behavior and academic tasks. The authors feel that the positive findings of this study warrant further study of the relative contributions of the self-instructional and reinforcement components.

Comment: This study was a pilot experiment with only three children. However, the results have led to further studies using this model.

Treatment Strategies

*Carter, E. N. & Shostak, D.A. (1980). Imitation in the treatment of the hyperkinetic behavior syndrome. *Journal of Clinical Child Psychology*, *9*(1), 63-66.

Synopsis: This article is a discussion of alternative procedures that can be used with children with hyperkinetic behavior syndrome.

Treatment approaches to hyperactivity have traditionally included behavioral interventions or psychostimulant medication. These authors feel that too little attention has been paid to the possibility that children with hyperactivity experience faulty auditory perception or impaired sequential processing. These difficulties would indicate that at least some of the children have a learning disability as a primary deficit. Some strategies that could prove effective may be imitation and augmenting auditory instructions with visually presented information.

The study described involved sixteen children diagnosed as hyperactive matched with sixteen who were not. All the children diagnosed as hyperactive were taken off medication at least four weeks prior to the beginning of the study. Both groups of children were randomly assigned to either a "model" group or a no-model group. Each group was asked to perform four tasks: 1) sitting on a couch; 2) arranging blocks; 3) written reproduction; and 4) verbal recall. One group received verbal instructions on how to complete the task (the no-model group). The model group received verbal instructions and a demonstration of how to perform the task.

The results of the study indicate that children who are hyperactive differ from those who are not hyperactive on certain cognitive and behavioral tasks. However, when presentation of the tasks included specific imitative modeling procedures, the differences were no longer evident. The authors acknowledge the limitations of this small research effort. However, they conclude, "With an increased emphasis on the examination of special educational programs for hyperactive children organized around the theme of more visual stimulation, more refined remedial procedures might develop as an adjunct, if not a replacement, for the current chemical and behavioral therapies."

Comment: This research points to future studies to find effective treatment techniques for children who are hyperactive and/or have learning disabilities.

Treatment Strategies

*Corder, B.F., Whiteside, L. & Haizlip, T.M. (1981). A study of curative factors in group psychotherapy with adolescents. *International Journal of Group Psychotherapy, 31*(3), 345-354.

Synopsis: These authors report on a study of perceptions of group conditions and experiences that promote positive change among adolescents involved in group psychotherapy.

Yalom developed a list of mechanisms and conditions within groups (curative factors) that are thought to produce behavior change. These factors include altruism, group cohesiveness, universality, interpersonal learning, guidance, catharsis, identification, family reenactment, insight, instillation of hope, and existential awareness. Research has focused on the correlation of patient characteristics with patient rankings of these factors in adult populations.

The subjects involved in this study were sixteen adolescents from four therapy groups in different clinical settings. Two were held in outpatient mental health centers, one in a regional child guidance clinic, and one in a regional psychiatry training program clinic. The latter group had both outpatients and patients hospitalized for short-term treatment. All the adolescents had attended groups for at least six months. The co-therapists for the groups described the therapeutic goals and their general orientation in response to a questionnaire. These goals were summarized as 1) development of more control of behavior through developing insight into the adolescents' own actions and behavior, and 2) opportunities for social learning and interaction. The majority of the therapists were psychoanalytically oriented in their treatment focus.

The adolescents sorted sixty cards describing the curative factors into seven categories ranging from most helpful to least helpful. They then participated in a brief interview regarding their reasons for the most helpful and least helpful items.

An analysis of the data collected indicated that there were no great differences between adolescents and adults in their perceptions of curative factors. The adults attributed more importance to insight factors where adolescents found group cohesiveness and universality most helpful. Neither adults nor adolescents felt they profited from direct guidance from other group members or modeling other's behaviors. Adolescents found difficulty in using insight-oriented direct-interpretation techniques. The results of this study have implications for pretherapy training programs for adolescents to teach techniques for the constructive expression of feelings and for giving feedback. There are also possibilities for training programs for therapists on techniques that allow expression without developing intolerable levels of tension and anxiety.

Comment: This article is a relevant contribution to information about group work with adolescents.

Treatment Strategies

Corder, B.F., Haizlip, T., Whiteside, R. & Vogel, M. (1980). Pre-therapy training for adolescents in group psychotherapy: Contracts, guidelines, and pre-therapy preparation. *Adolescence, 25*(59), 699-706.

Synopsis: This article is a description of a program developed for out-patient adolescent psychotherapy groups.

This program was developed and utilized in a community mental health center and with a limited number of hospitalized adolescents. The initial goals were: 1) to offer written guidelines and direction for expected behaviors; 2) to provide videotaped examples of peers for the adolescent to model; 3) to deal at the outset of therapy with confidentiality issues; 4) to require a literal written contract to establish clear goals and expectations for the adolescents, their parents, and the therapists; and 5) to establish realistic and positive expectations and perceptions of involvement and improvement in therapy.

After an initial screening interview, adolescents were seen individually in two separate one-hour sessions with their group co-therapists. They were shown a videotape that reviews typical questions and concerns, describes a therapy contract, shows a group in progress and reviews the guidelines for participation. They received a packet of written guidelines that includes instructions on giving and receiving feedback, describes expected behaviors, and reviews some basic Transactional Analysis concepts. The material in the packet was discussed with the therapists. A written contract outlining individual goals and expectations was formulated, discussed, and reviewed by adolescents, parents, and therapists.

Adolescents are expected to attend the group once a week, to talk about feelings and problems, to listen to others, and to try to help them. They pick some problem areas to work on and are willing to discuss these with the group. Parents are expected to provide transportation and be involved in collateral parent therapy if it is available. They are expected to contact the therapists if they have questions or concerns. All specific things said in the group are confidential and will not be shared with parents unless the adolescent agrees to it. Parents receive periodic letters from the group written by the therapists, group members, and their adolescent.

The therapists feel that the pre-therapy training program resulted in earlier development of group cohesion, an increase in ability to give and receive feedback, and a decrease in drop-out rates.

Comment: This article is a description of an aspect of group work with adolescents that is rarely addressed.

Coster, W. (1980, April). *Teachers and occupational therapists: A partnership for children with special needs: The role of the therapist with emotionally disturbed children.* Paper presented at the Annual International Convention of the Council for Exceptional Children, Philadelphia, PA (Eric Document Reproduction Service No. ED 188 413.)

Synopsis: This paper is an examination of the role of an occupational therapist in the education of children with emotional disorders.

A portion of the children who have emotional disabilities have signs of neurological dysfunction including unusual sensitivity to sensory stimuli, postural immaturity, and disturbances in reactions to movement. Although there have been no comprehensive explanations for these neurologic phenomena, there is increasing agreement that emotional disability in certain children is an outcome of some disturbance in central nervous system functions, usually those regulating sensory processing, arousal and attention, and planning of complex movement.

One characteristic of children experiencing these types of difficulties is an "odd" physical appearance. They may walk with an odd gait or lunge forward when jogging in place. These indicate there may be a problem with postural integration; the children lack adjustments necessary for equilibrium. Some do not have a normal response to the sensory input from movement. They may spin furiously without seeming to get dizzy. In many ways, these children are out of control. Everyday experiences can be stressful and disorienting.

In working with these children one role of the occupational therapist is to translate the child's behavior in light of the sensory perception deficits. It is then possible to set reasonable expectations and plan necessary adaptations. The occupational therapist can help children learn that they are separate from their environment and teach them how to gain control over some of their basic movements.

Even with children without neurologic symptoms, occupational therapists can help structure activities that capitalize on strengths to provide experiences of mastery, self-control, and cooperation.

Comment: Though occupational therapy has been identified as a service to those who have a physical and mental disability, it is only recently that it has been recognized as a service to help treat children with emotional disabilities.

Treatment Strategies

DiGiuseppe, R. & Bernard, M.E. (1983). Principles of assessment and methods of treatment with children. In A. Ellis & M.E. Bernard (Eds.), *Rational-emotive approaches to the problems of childhood*, (pp. 45-87). NY: Plenum Press, 45-87.

Synopsis: This chapter is a description of the use of rational-emotive therapy (RET) with children.

Most of the work with RET has been with adult populations. This type of therapy hypothesizes that disturbed emotions are generated by beliefs, and irrational ideas and distortions of reality create anger, anxiety, and depression. RET differs from direct cognitive-behavioral solutions in that it is oriented toward emotional problem-solving.

The first task of the therapist is to explain to the child who psychologists are, who they help, how they help, and what they help people with. Rapport is very important; without it children will not communicate verbally. It is essential that the therapist be honest and discuss how therapy can achieve the ends the child desires. The first step in treatment is to focus on the consequences of the child's present behavior. The authors state, "Before one can proceed to identifying and disputing irrational beliefs, one must first agree on a goal. Before one can agree on a goal, it might be necessary to expand the child's schema concerning emotional reactions so the goal is within his or her frame of reference." It is important that the therapist use jargon-free language; for very young children pictures and stories are helpful in explaining and eliciting information.

A cognitive-behavioral and emotive approach to assessment considers two elements. Problem identification uses formal and informal tests to determine if there is a problem. It is advisable to contact others who know the child. Secondly, the problem is analyzed; this is an ongoing part of therapy. During the analysis, the therapist considers cognitive areas of concern. The therapist needs to help children be more aware of their feelings and enable them to tune into and report their "self-talk." There are a number of scales and methods to help the child learn these skills, such as feeling charts, puppets, sentence completions, and guided imagery.

RET is a cognitive-behavioral therapy; it is important to get children to behave differently. Parents should help structure the behavioral components of therapy. The authors state, however, "Although behavioral approaches to fear have achieved some success, it has not been the total improvement that one would expect. A cognitive-behavioral program, though, may be more successful. The behavioral incentives provide the motivation to change, and the cognitive interventions help to foster that change and to reduce the fear." The two sets of skills taught in RET are emotional-problem-solving skills and practical-problem-solving skills. Emotional problem solving involves understanding helpful and hurtful feelings, that feelings come from thoughts, and that thoughts control feelings. Children are made aware of their self-talk, of the connections among behaviors, emotions, antecedent events, and their self-talk and beliefs and the difference between rational and irrational beliefs. A final aspect of teaching emotional problem-solving skills is demonstrating how cognitive change can occur and how this can influence emotions and behaviors. Sometimes it is necessary for a therapist to challenge irrational beliefs and help the child learn that events are not as catastrophic as they appear.

Comment: This chapter includes case illustrations of how to work with children using RET.

DiGiuseppe, R. (1983). Rational-emotive therapy and conduct disorders. In A. Ellis & M.E. Bernard (Eds.) *Rational-emotive approaches to the problems of childhood*, (pp. 11-137). NY: Plenum Press.

Synopsis: This chapter is a description of how rational-emotive therapy (RET) can be used in treating children with conduct disorders.

Children with conduct disorders are best diagnosed by what they do rather than by their thoughts, feelings, or family history. These children are often behaviorally and cognitively impulsive. Behaviors have to be assessed in terms of frequency, intensity, duration, and severity. The child's aggressive and noncompliant behaviors seem to be modeled, learned, or reinforced directly or nondirectly. The emotional component includes anger and frustration.

DiGiuseppe believes that RET can be combined with behavioral approaches in treatment of conduct disorders to: 1) augment gains and enhance the generalization of behavior change; 2) help to reduce the anger in children; 3) help parents resolve the problems that prevent them from adhering to behavioral treatments; and 4) teach children to be less impulsive and to think through behaviors before acting.

Two cognitive-affective clusters predominate in children with conduct disorders -- they feel anger because they must have their way, and they have a low tolerance for frustration (discomfort anxiety). In treatment children learn social-problem solving; they develop the ability to generate alternative solutions to problems. Self-instructional training is another approach; it is based on the idea that conduct problems develop because of the absence of appropriate thought and verbal mediational control. The author recommends the following steps in treatment of conduct disorders: 1) assessment of behavioral and emotional targets and assessment of behavioral contingencies; 2) development of rapport with the child; 3) assessment of the parents' child management skills, their emotions toward the child and the misbehavior and their philosophies of child rearing; 4) cognitive-behavioral interventions to change disordered parental emotions; and 5) cognitive interventions aimed at child's cognitions and emotions.

During assessment both parents and child should help define the target behaviors objectively and clearly. The contingencies and consequences of these behaviors are assessed and philosophies of child rearing are discussed with parents. Work with parents follows a RET format of disputing irrational thoughts to relieve guilt and anger. This enables parents to adhere to the behavioral regime with the child which in turn places the child in an uncomfortable position which may motivate him/her to participate with the therapist. The steps in an ideal therapeutic situation with a child with a conduct disorder are: 1) the events should be actual situations in which the child has experienced the emotional or behavioral problem; 2) the emotional vocabulary of the child should be expanded; 3) the irrational beliefs causing the disturbed emotions are identified and disputed; 4) specific self-instructional statements are taught to inhibit immediate responding, to focus on cognitive disputing, and to guide appropriate behavior; and 5) social-problem-solving skills such as alternative solutions and consequential thinking are taught to avoid problem situations in the future.

Comment: This chapter contains a nice section of working with parents who are involved with a behavior management program. For a description of RET, see DiGiuseppe & Bernard (1983) in this volume.

*Dubey, D. R., O'Leary, S.G. & Kaufman, K.F. (1983). Training parents of hyperactive children in child management: A comparative outcome study. *Journal of Abnormal Child Psychology, 11*(2), 229-246.

Synopsis: This article is a description of a study of the efficacy of training parents of children with hyperactivity.

Traditionally, children with hyperactivity have been treated with psychostimulant medication with generally positive results. Lately, however, there have been concerns about the side effects of drugs, the fact that some children do not respond, and the lack of improvement in achievement test scores. Because of these concerns, treatment providers have been exploring nonpharmacological methods of working with children who are hyperactive. Generally these methods are behaviorally-oriented and have occurred in school settings. However, home management remains an issue even for children on medication. Parents can become the change agents for their children in two ways: 1) through individualized services from a professional whereby parents are the mediators of suggested therapeutic procedures; and 2) through a group education model. Two group training models are a behavioral approach based on learning principles and a reflective approach with an emphasis on attitudes, feelings, and communication.

The study described in this article compared the behavioral and reflective approaches to working with parents of children who were hyperactive. A total of 44 families were recruited and 18 were assigned to the reflective group, 19 were assigned to the behavior modification group, and 7 to a delayed-treatment control group.

The behavior method ("Parents are Teachers" or PAT) involved a 9-week course with reading assignments, lecture-discussions, and homework assignments involving pinpointing, observing, and recording target behaviors, counting and recording parental rates of praise and criticism, and designing and implementing change programs. The reflective model (Parent Effectiveness Training or PET) also involved 9 weeks with reading assignments, homework exercises, and lecture-discussions. The course taught parents to recognize and eliminate inappropriate types of communication, to use more facilitative modes of communication, and to use skills to resolve parent-child conflicts.

Parents were administered a battery of tests and two laboratory tasks both pre- and post-training. There was also a follow-up at 9 months. The results of the analysis of the data indicated that the education classes led to significant reductions in parent reports of the severity of hyperactivity and behavior problems in their children as compared to children of parents in the control group. In comparisons of the two educational programs, the behavior modification program produced greater change on several measures, including: 1) more global improvement in problem behaviors; 2) more willingness to recommend the course to a friend with similar problems; 3) the feeling that the course was more applicable to their problems; and 4) less likelihood of dropping out of the program. At the 9-month follow-up, gains were maintained.

Comment: These authors presents options for parents whose children are taking medication for hyperactivity.

Treatment Strategies

*Dumas, J.E. & Albin, J.B. (1986). Parent training outcome: Does active parental involvement matter? *Behavior Research and Therapy, 24*(2), 337-230.

Synopsis: This article is a follow-up study of Dumas' earlier research on why parent training is successful or unsuccessful. The focus is on the relevance of parental attendance at training sessions.

Previous research indicated "a steady increase in the probability of treatment failure in two standardized parent training programs as the sample families' adverse social and material conditions increased." The study described in this article was conducted to investigate whether success of a program depends on regular attendance at training sessions and compliance in carrying out instructions and programs with the children. The sample included 82 families who had completed a home-based parent training program. The children (2 to 15 years old) were described as out-of-control, aggressive, and non-compliant. An assessment conducted at intake determined the social and material factors ("setting events") of the family. The setting event measures included in this study were: 1) child's previous services; 2) father's presence in the home; 3) marital violence; 4) mother's psychopathological symptoms; 5) family income; 6) family size; 7) mother's education; and 8) source of referral.

The treatment program in the home lasted six to ten weeks. Parents learned the principles of reinforcement of appropriate behaviors and the use of nonphysical, aversive consequences (such as time-out) for noncompliant, aggressive behavior. There was an emphasis on careful daily tracking and contingent and consistent punishment of inappropriate behavior.

Outcomes were assessed twelve months after treatment. Success was defined as completing the program, applying the necessary parenting skills, and no use of additional professional help. The measures of parental attendance and compliance with program instructions did not account for any significant amount of variance in outcome. Setting events which were relevant were mother's psychopathological symptoms, child's previous services, father's presence, source of referral, and mother's education. The author feels that one explanation is that although parental involvement is necessary, it may not be enough in many "high-risk" families. This may reflect "more than a lack of parenting skills on her part or on an inadequate training program. It may also reflect the broad ecological context in which mother and child function." On the clinical level, some families may require additional services for parent training to be successful.

Comment: This study shows that enduring adverse ecological conditions are not conducive to a structured and somewhat time-consuming intervention.

*Dumas, J.E. (1984). Interactional correlates of treatment outcome in behavioral parent training. *Journal of Consulting and Clinical Psychology.* *52*(6), 946-965.

Synopsis: This article is a description of a study of a behavioral parent training program to modify aggressive and oppositional child behavior.

Evaluations of parent training programs have shown mixed results. The study reported in this article was conducted to compare the qualitative differences in mothers' disciplinary practices as that effects success or failure in a parent training program. The study included fifty-two mother-child pairs who participated in a behavioral training program to modify oppositional child behavior. All families had sought help or were referred to the Child Behavior Institute of the University of Tennessee in Knoxville.

Parent training included three phases--baseline, treatment, and follow-up. The baseline period lasted four to six weeks and measured parent-child interaction prior to treatment. The treatment phase lasted approximately seven weeks and was conducted by trained therapists who worked individually with the families once a week. The program was designed to teach parents to use time outs and a point reward system to increase the child's rate of desirable behaviors. The follow-up phase lasted approximately one year. The therapist stopped coaching the parent but was available to offer advice when it was requested.

Throughout the study data were collected in the home. During the first two phases data were collected twice a week. Observations occurred once a week for the first month of follow-up and every two weeks thereafter. Home observations were conducted by trained students using a coding system. Outcome was evaluated at a one-year followup whereby families were assigned to a success group (n=21) or failure group. The failure group was divided into those who dropped out early (n=21) and those who completed all three phases (n=10).

The results of this study indicate that "mothers who failed in parent training were more aversive than their successful counterparts throughout intervention and that their children were more aversive than successful children in treatment and follow-up." There was no difference in levels of maternal aversion between the drop-out group and those who failed but completed the program. Socioeconomically disadvantaged mothers had a higher failure rate and evidenced a higher level of aversive behaviors. Dumas attributes this in part to "the fact that it may be most difficult for such mothers to learn to display the prosocial and consistent contingencies taught in training when they are repeatedly faced with aversive stimuli in their environment." The author suggests that future studies should explore the link between contextual variables and family interactions so disadvantaged mothers could benefit from parent training.

Comment: This article, although technical in nature, shows a degree of sensitivity toward parents not always apparent in research reports.

Treatment Strategies

Elder, J.P., Edelstein, B.A. & Naric, M.N. (1979). Adolescent psychiatric patients modifying aggressive behavior with social skills training. *Behavior Modification*, *3*(2), 161-178.

Synopsis: This article is a description of an attempt to modify the behavior of adolescents who are aggressive.

The authors discuss some strategies that have been used to manage aggressive behaviors in adolescents. These include contingency management programs with time out and positive reinforcement; a social learning approach using modeling of nonviolent alternatives; and combinations of these two approaches. The project reported in this article attempted to determine the generalizability of social skills training in reducing aggressive behaviors in adolescents.

The study involved one female and three male adolescents in an adolescent unit of a large state psychiatric hospital. Their mean length of hospitalization was 4.9 years (two months to five years). All four adolescents had histories of verbally and physically aggressive behavior. The general treatment model on the ward was based on that of Achievement Place with a point system, ward government, and academic classes. In relation to these four adolescents, there was no decrease in aggressive behaviors observed before the study. The group social skills training took place in an on-ward classroom with two therapists. Target behaviors were determined by staff members and interviews with the four adolescents. The behaviors selected for modification were 1) interruptions, 2) responses to negative communication, and 3) requests for behavior change. The group met for four days a week for about forty-five minutes a day for fourteen weeks. The adolescents role-played various scenarios designed to deal with these behaviors. As treatment, the therapist provided feedback, instructions, and modeling. The two therapists rated the responses of the adolescents and compared these ratings to baseline data on each youth in each behavior category.

The results of this small study suggest that supplying alternatives to aggressive behaviors can be effective. Generalization to situations other than the treatment setting occurred which resulted in fewer fines and time spent in seclusions, which were part of the behavioral treatment strategy of the ward. The authors conclude, "Adolescent aggressive behavior can be effectively modified by social skills training. Such training offers alternatives to aggressive responses, in contrast to merely punishing them or reinforcing incompatible behaviors."

Comment: This article, although a description of a very small study, makes a contribution to a growing movement toward social skills training.

*Fleischman, M.J. (1982). Social learning interventions for aggressive children: From the laboratory to the real world. *The Behavior Therapist*, 5(2), 55-58.

Synopsis: This article explores therapist performance and client outcome in both laboratory and field settings.

Behavior therapies are generally laboratory-based, rather than clinically derived, models of intervention. Because of this, behavioral programs have a fairly strong empirical base. A disadvantage of the laboratory-based models is their applicability to field settings.

The author designed a study to compare the results of a laboratory-based program of social learning intervention for aggressive children to a field trial of the same program. The initial program was developed at the Oregon Social Learning Center and was field-tested in a mental health clinic and two protective services units of the state's Children's Services Division. The field therapists received two weeks of intensive training and ongoing supervision by project staff.

Therapist performance was evaluated on: 1) knowledge of social learning theory and program specifics; 2) extent to which they covered relevant items in the course of monitoring parents over the phone; 3) extent to which trainees spent session time on the behavioral parent training component as opposed to more general counseling or conversations; 4) clinical quality of the in-session client-therapist interaction; and 5) amount of clinical contact. Child performance was measured on 1) incidents of aversive behavior and 2) parent daily reports of occurrence of behaviors that concerned parents.

The results of analysis of the data gathered indicate that there were both quantitative and qualitative deficits in performance of the field therapists when compared to the project therapists. Also there were fewer improvements in child behaviors over time and treatment was briefer in the field sites.

To transfer interventions from the laboratory to the field, Fleischman recommends the following: 1) assessing the variables related to an organization's readiness to change; 2) breaking implementation into distinct phases such as gaining entry, exchanging information, establishing commitment, installing the program, and facilitating maintenance; 3) allowing therapists in the field several months of concentrated clinical experience to become proficient in the use of the model; and 4) providing qualified on-site supervision.

Fleischman stresses the importance of expanding successful laboratory-developed interventions to real world situations. Attention needs to be given to how this transfer can be implemented effectively.

Comment: This article addresses an issue present in the discussion of many treatment interventions, which is the efficacy of the use of a model in actual practice.

Treatment Strategies

Golden, J.M. (1981). Depression in middle and late childhood: Implications for intervention. *Child Welfare, 60*(7), 457-64.

Synopsis: This article includes a discussion of depression and treatment of depression in children.

There is still controversy about whether children can be diagnosed as depressed. Of those who believe that there is such a disorder as childhood depression, most feel the signs could include feelings of overall sadness, a lack of sense of self-worth, feelings of anger and hostility over a loss, acting out behavior, and any number of somatic complaints.

In middle childhood (from ages six to eight), intervention goals are to build or strengthen areas of gratification and esteem and to remove or diminish the source of frustration. At this age, environmental intervention and parental involvement are necessary. In late childhood (ages nine to twelve), the author feels that the most appropriate treatment is individual psychotherapy. The therapist should be concrete, specific, and practical. The author adds, "For the therapist committed to an ecological point of view, the school, peers, neighbors, and others may also be significant areas for intervention."

Comment: Golden focuses on psychotherapeutic interventions; however, she often refers to ecological approaches to working with this population.

Green, D. (1980). A behavioural approach to the treatment of obsessional rituals: An adolescent case study. *Journal of Adolescence*, *3*, 297-306.

Synopsis: This article is a description of an infrequent but complex and distressing disorder--obsessional-compulsive rituals. A case study is presented.

Green discusses a behavioral program designed to control adolescent obsessional-compulsive rituals. Most behavioral techniques have been successful in blocking the urge to perform compulsive activities. However, behavioral research has produced little in the way of techniques geared toward changing obsessional thoughts. One exception has been the use of relaxation therapy to reduce autonomic reactions to environmental triggers. Relaxation techniques are generally used in conjunction with desensitization methods.

The treatment model described in this article used three therapeutic techniques: 1) autogenic training; 2) satiation training; and 3) response prevention. Autogenic training is a method of relaxation in which "appropriate psychophysiological responses are induced using a well-defined series of self-instructions." Because of the rigid format for teaching this technique, it has been suggested that it is appealing and suited to those with obsessional disorders.

Satiation training requires that the person deliberately evokes an obsessional thought and maintains it without any "putting right" activity to ease the discomfort. The theory is that once the person gets used to the discomfort of the obsessional thought, the capacity to resist it increases.

Response prevention is instructing the person to cease all ritualistic behaviors and to keep a weekly record of success. This technique is similar to satiation training in rationale. For children, it is appropriate for family members to intervene to physically prevent repetitive behaviors.

The case study described here involved a 15-year old male with obsessional checking behaviors. The treatment techniques were employed and were successful and progress was maintained at six month follow-up. The author feels that this particular approach "may be particularly attractive for adolescents to whom issues of independence and autonomy from parents are of major importance, and who thus would perhaps feel uncomfortable taking part in a treatment programme such as a response blocking technique, which relied heavily on adult instruction and participation."

Comment: The techniques described here include a unique combination of components to treat a rare but complex disorder.

Treatment Strategies

Green, M.R. (1983). Treatment of borderline adolescents. *Adolescence*, *23*(72), 729-738.

Synopsis: This article is a discussion of borderline disorders in adolescents and treatment strategies to deal with them.

Adolescents with a borderline disorder have extreme fluctuations in mood, great difficulty sustaining significant relationships, and are very vulnerable to disappointment, rejection, and separation. Adolescents may or may not experience transient psychotic episodes, and they frequently experience symptoms of schizoid processes, withdrawal, and depression. The author states, "Borderline adolescents seem to come from parents, one or both of whom manifest a borderline syndrome and who have failed their child particularly in the critical developmental periods of separation-individuation."

The treatment strategies include five important points: 1) therapists must be very active in initiating and maintaining therapeutic movement; 2) they must maintain a simple, direct, unique person-to-person relationship but avoid acting out countertransference feelings of anger or overprotective nurturing; 3) they must pay special attention to feelings and behavior apart from the verbal content of the sessions; 4) they must avoid premature interpretation, intellectualization, or any tendency to encourage regression; and 5) emotional engagement in the therapeutic alliance is more important than providing insight through interpretation. However, properly timed insights can discourage regressive tendencies.

The author worked extensively with the families of the adolescents, and eventually confronted the parents with their ambiguous behaviors. The parents were shown examples from their own childhoods.

Comment: Although the author focuses blame on parents, the case examples illustrate how work with families, as well as the child, can be positive to all members.

Treatment Strategies

Griest, D. & Wells, K.C. (1983). Behavioral family therapy with conduct disorders in children. *Behavior Therapy*, *14*(1), 37-53.

Synopsis: This article is a review of data concerning the impact of family variables on the treatment of child behavior problems, especially conduct disorders.

The authors contend that a parent training approach to treatment of conduct disorders in children is not always effective or longlasting and is, at times, inappropriate. An expansion of the behavioral family therapy model should include assessment of cognitive parent variables (e.g., perceptions of child behavior), psychological parent variables (e.g., depression, anxiety), marital variables, and social variables (e.g., extended family, community relationships). The authors state, "Behavioral family therapy has outgrown the simple parent-training model and has become increasingly more complex."

Parental perceptions of child behavior can fall into one of three groups: 1) those whose child is behaviorally deviant and the parents are accurate in their perception; 2) those whose child is deviant but perceptions are influenced by the parents' own maladjustment; and 3) those whose child is normal and the parent's perceptions are inaccurate and based on their own personal maladjustment, low tolerance for stress, or high standards of acceptability rather than on their child's normal behavior. The authors believe parent training programs incompletely serve parents in the second group and are totally inappropriate for the third group.

It has long been felt that there is a relationship between conduct disorders in children and parental psychopathology, especially depression and anxiety. Three explanations for this phenomenon are: 1) parental maladjustment causes child behavior problems; 2) the child's behavior is responsible for the parents' adjustment problems; or 3) the etiology may be due to an unidentified factor such as life stresses. Evidence also exists that there is a relationship between marital adjustment and child behavior problems; however the relationship is not clear. Does marital discord influence child behavior or do child behavior problems exacerbate marital relationships?

A recent concern has focused on interpersonal relationships outside the family in relation to both the quality and quantity of contacts. One theory is that the lack of social supports may lead to vulnerability to life stresses which can influence parent-child relationships.

Behavioral family therapy and training has made great progress in the treatment of child conduct disorders. However, there are large gaps in knowledge of the interplay of various family variables which suggests that a "sequence of treating target areas in the family must be delineated."

Comment: This article is a presentation of alternative ways of viewing families when designing parent training programs to deal with childhood behavior disorders.

Treatment Strategies

Hepworth, D.H., Farley, O.W. & Griffiths, J.K. (1988). Clinical work with suicidal adolescents and their families. *Social Casework, 69*(4), 195-203.

Synopsis: This article is a discussion of psychosocial factors associated with adolescent suicide attempts and treatment implications.

Psychosocial risk factors for adolescent suicide fall into three stages: predisposing factors, escalation of problems related to adolescence, and the period of weeks or days immediately preceding a suicide attempt. Some predisposing factors include loss of a parent through death or divorce, child abuse, long-standing family difficulties, and behavioral indicators evidenced as early as first grade (underachievement, aggression). Problems that escalate during adolescence include school-related behavior problems, substance abuse, communication deficits, and erosion of family relationships. Precipitating events immediately before a suicide attempt could be related to separation or threatened separation from a loved one (parents, sweetheart), conflict with parents, school problems, and peer problems.

In assessing suicidal risk a practitioner needs to obtain information from parents and significant others, interview the adolescent, administer instruments designed to assess depression and suicide risk, and to clinically observe the adolescent. Since adolescents often do not disclose personal information, skillful interviewing is required. It is also necessary for the practitioner to evaluate the family.

After assessment has revealed that an adolescent is suicidal, the immediate treatment is crisis intervention. The practitioner should consult a psychiatrist because of the possibility of the need for antidepressant medication and hospitalization. Individual therapy combined with family or group therapy is often indicated. Individual therapy is integral in that it allows the opportunity for adolescents to express feelings they may not verbalize in family or group settings. The therapy should focus on gaining awareness of emotions, coping strategies, enhancing self-esteem, and developing communication skills. Family therapy is usually preferred over group therapy because of the ongoing availability of the family as a support system and the strength of the emotional bonds. It is an effective way to reduce family conflicts and increase communication. If family therapy is unfeasible or the family is not a viable support system, group therapy is an alternative. Peer support can lessen the adolescent's feelings of isolation.

The author also suggests that the clinician can spearhead efforts to organize other support systems for adolescents who are suicidal, such as church groups, youth or volunteer organizations, and other informal resources.

Comment: The authors present some treatment strategies for adolescents who are suicidal. Of special interest to clinicians might be individual therapy techniques.

Treatment Strategies

Herman, B.E. (1980). A sensory integrative approach to the psychotic child. *Occupational Therapy in Mental Health, 1*(1), 57-68.

Synopsis: This article is a description of the contributions occupational therapy can make to the assessment, treatment, and understanding of a child's psychotic condition.

Herman believes that bizarre behaviors, distorted thinking, and inappropriate emotional responses are a child with a psychotic condition's attempt to cope with reality as he or she perceives it. These are manifestations of faulty underlying neurophysiological mechanisms. Occupational therapy, and in particular sensory integrative therapy, is a natural remedy for the central nervous system dysfunction associated with the child with a psychotic disorder. As stated in the article, "Occupational therapy applies a neurological and developmental frame of reference to children who are neurologically and developmentally impaired."

The bulk of this article is a case study of a 9-year old girl who is psychotic and self abusive. In four years of institutionalization, various therapies were attempted, including milieu, psychotherapy, behavior modification, and chemotherapy, and none were successful. The intensive sensory integration program is neurodevelopmentally based using a natural, body oriented active therapy. It takes children's own interests and play activities and then designs them to provide the stimulation needed to help normalize the children's central nervous system.

Statistical and behavioral reports documented improvement in functioning and a reduction in self-abusive behavior in the case described in the article. Progress was slow, and as self abusive behaviors decreased, aggressive, abusive behavior toward others increased. This was perceived as a positive progression even though it precluded a normal therapeutic progression.

Comment: The appeals of this approach to working with children with psychotic disorders are the idea of accepting the developmental level of the child and preceding from that point and not attaching blame.

Hoffer, A., Goettsche, R. & Linden, F. (1980). A psychoanalytic approach to a therapeutic impasse with an impulsive adolescent: Permission to speak the unspeakable. *American Journal of Psychiatry, 137*(11), 1404-09.

Synopsis: This article is a description of work with an impulsive, intermittently psychotic boy using a traditional psychoanalytic approach.

When adolescents recover from a psychotic episode, they often become aggressive, sadistic, antisocial, and maybe suicidal, which are defenses against intolerable affects and fantasies. The authors of this article do not think staff should focus exclusively on attempts to control behavior. Psychotropic medication is not very beneficial in this post-psychotic phase. The behavior of the patient becomes very frustrating to the therapist and family, and often inappropriate planning and referrals occur out of desperation.

The authors describe one way to get through this impasse by describing a particular case. They conclude that this type of patient should be encouraged to "put their feelings into words within the therapeutic alliance" in the classic psychoanalytical sense. The authors feel that, "Only after the patient's behavior is defined as acting out in the classical sense, rather than habitual random acting up, will it be possible to encourage the patient to extract the painful memories from a reenactment of the past." In the case described here, the aggressive, impulsive, destructive behavior of the patient decreased as he began to verbalize his sexual feelings for his mother and the therapist. He still had psychotic episodes, but his impulsive behavior lessened after the episodes.

Comment: The authors urge therapists to return to psychoanalytic traditions when other treatments are not effective in dealing with this particular population of adolescents.

Treatment Strategies

Holmes, P. (1987). Boundaries or chaos: Psychodrama with adolescents. In J.C. Coleman (Ed.). *Working with troubled adolescents* (pp. 91-106). London: Academic Press.

Synopsis: This chapter is a description of the use of psychodrama with adolescents with a focus on boundaries used to contain anxiety and stress.

In discussing boundaries, the author lists three forms: emotional, rules and permissions, and physical. Within these three forms, a hierarchy exists ranging from situations closest to the patient to those most distant. This chapter describes an outpatient group session using psychodrama; the group included five adolescents and two therapists. Selection of group members is important and the process varies depending on characteristics of the adolescents. Holmes believes it is crucial that there is some desire to change on the part of the adolescent. Ground rules need to be explicit and agreed to by the youth in an individual session before they enter the group. In the group described here, rules included: 1) a wish to join with no coercion; 2) an attempt to participate; 3) no direct violence; 4) stay in the room even during stressful periods and attempt to attend regularly; and 5) maintain confidentiality.

Psychodrama usually begins with "warm-ups" to increase group cohesiveness and stir up issues for later in the session. One example of a "warm-up" is a guided fantasy exercise whereby the therapist talks to the whole group, taking them on an imaginary journey with choices for the youth along the way.

The members then discuss the choices they made and explain why they were made. The therapist asks for a volunteer to do more work on the choice through a psychodrama. When more than one volunteers, the group selects the problem; if no one volunteers, more warm-up may occur or smaller sub-groups may present short improvised skits. The person chosen to work becomes the protagonist (the one on center stage). One therapist is the director. Psychodrama consists of the director talking to the protagonist while directing him to assume various roles, including role reversal. Other adolescents can withdraw (but not leave the room) or become involved as a player in the psychodrama. Another element of the psychodrama is sharing or expressing feelings stirred up about themselves. Holmes feels that some degree of self-revelation on the part of the therapists facilitates the group process. The session ends with coffee and cookies to help all members relax and regain composure.

This chapter contains a step by step illustration of a group session using psychodrama. The author explains the use of boundaries and "containment" within the context of the illustration.

Comment: Although technical and psychoanalytic in terms of language, the techniques of psychodrama are clarified by the ongoing case illustration.

*Jamison, R.N., Lambert, E.W. & McCloud, D.J. (1986). Social skills training with hospitalized adolescents: An evaluative experiment. *Adolescence*, *21*(81), 55-65.

Synopsis: This article is a description of an evaluation of a social skills training program with hospitalized adolescent males.

Adolescents placed in residential psychiatric facilities lack the skills to behave appropriately in social settings. They frequently overreact or underreact in anger-provoking situations. Traditional treatments for antisocial behaviors have been by and large unsuccessful. There has been some evidence that social skills training can be successful in helping adolescents control aggression. This treatment substitutes new skills for inappropriate behavior. The study described in this article was designed to assess social skills training against a control group matched for age using "blind" raters.

The subjects were twelve males, ages fifteen to seventeen, in a state psychiatric hospital. Nine had a DSM-III diagnosis of conduct disorder while three were diagnosed as having an adjustment disorder. Seven were chosen as the experimental group and five were identified as controls. One boy from the experimental group was discharged prior to completion of the training.

The training consisted of five one-hour sessions in which verbal response, eye contact, and facial expression were taught through modeling, role-playing, group discussion, and observation of videotapes. At the end of each session, the adolescents were assigned homework related to the session's topic. Staff selected ten anger scenarios which were presented to both the experimental and control groups individually pre-and post-training. The boys' responses were videotaped and rated by outside observers.

The ratings revealed that desired verbal responses increased in adolescents involved in the training but not in the controls. It was also found that positive eye contact increased. However, training failed to show significant improvement in the rated measure of facial expression. Ongoing evaluation is needed to determine the generalizability of the training outside the facility setting.

Comment: This study was small but confirmed previous work and hypotheses regarding the efficacy of social skills training with adolescents who are aggressive.

Treatment Strategies

*Jansen, D. (1986). Benefits of a family oriented approach in adolescent treatment. *Social Casework, 67*(97), 410-17.

Synopsis: This article is a description of an adolescent day treatment program with a family rather than individual focus.

Two modes of intervention were used at a midwest day treatment program at different times -- one individual-oriented and one family-oriented. Both modalities included group therapy, individual counseling, occupational therapy, and family therapy. The individual oriented approach focused on behavioral or cognitive changes by the adolescent. The family-oriented treatment focused on change within the organizational structure of the family. When the individual-oriented program was in effect, staff were concerned because even though the students' grades improved and delinquent acts were reduced, many were placed out-of-home after discharge and a number of families experienced a repetition of problematic behaviors.

In the family-oriented approach, the treatment follows certain stages: 1) initial hypothesis; 2) ten-day evaluation; 3) individualized treatment plan, recommendation, and placement; 4) correction of the family hierarchy; and 5) second-order change. The initial hypotheses are formed by reviewing previous psychiatric, psychological, and clinical evaluations, school reports, and court depositions. The ten-day evaluation includes clinical and psychiatric evaluation, a social skills test, and an occupational therapy activity lab. After the evaluation, the evaluators develop an individualized treatment plan that is presented to the parents who have the authority to decide if their child will be involved.

Correcting the family hierarchy means realigning the family to strengthen the parents' authority over the child. Some therapeutic interventions that help accomplish this are: 1) during therapy sessions, acknowledging the parents first; 2) parents sit next to each other; 3) parents dictate appropriate rules of behavior and consequences of inappropriate behavior; 4) parents establish goals for the family; 5) the therapist does not offer that the parents' marital conflicts "cause" the child to act the way he or she does; 6) the adolescent is not allowed to interrupt an adult discussion; 7) parental disagreements are not openly explored or resolved until the child is acting normally; and 8) parents decide if they wish to contract for further therapy to resolve marital conflicts.

The first-order of change is the elimination of problematic behavior. In work with the family, the therapist promotes second-order change to prevent the adolescent from regressing and to help the family members relate toward one another in a less destructive manner. This is achieved through paradoxical interventions whereby the problem behavior is redefined positively, is prescribed, and the family is restrained from changing. The dilemma is that, "if the family wants the child to behave normally, they are to recognize that a second-order change must occur within the organizational structure of the family."

The results of the change from an individual orientation to a family orientation were that there were fewer post-discharge out-of-home placements and families were served in a shorter period of time. Follow-up data revealed that those adolescents involved in the family-oriented approach exhibited fewer problematic behaviors.

Comment: This approach to parental empowerment is interesting; the use of paradoxical interventions may be controversial to many practitioners.

Treatment Strategies

Johnson, G. O. & Boyd, H.F. (1984, April). *The coping style approach to understanding and dealing with behavior disorders: Assessment and intervention strategies.* Paper presented at the Annual Convention of the Council for Exceptional Children, Washington, D.C. (ERIC Document Reproduction Service No. 245 478).

Synopsis: This paper is a description of the uses of an instrument to assess coping styles of children who are have emotional disabilities.

An instrument called the Assessment of Coping Style was developed to obtain information on coping styles youngsters use to deal with problems. It was initially designed for use with children who were classified as having an emotional disorder and who were having interpersonal relationship problems with peers and authority. The instrument consists of 20 drawings of persons in various settings. The subject selects one of six statements that represents the feelings of the designated person in the picture.

Once a coping style has been identified, intervention strategies can be formulated. One strategy is to remove the opportunities to continue to use that style of coping. Next, the child is taught to select alternative, more appropriate styles for specific situations. The teaching method depends on the developmental level of the child -- puppets, role play, counseling, etc.

The authors present an example of children who tend to use externalized attack coping behaviors -- belittling, blaming, name-calling, cheating, kicking, biting, hitting, screaming, etc. The environment should be structured so these children cannot use these behaviors which may include moving them away from the group, walking with them, restricting their supplies and materials, and requiring restitution for things they destroy. Teaching alternative behaviors could involve techniques such as reinforcing appropriate behaviors, peer pressure, clarifying assignments, and "what would happen if. . ." statements. The authors also discuss the use of strategies with the other identified coping styles including externalized avoidance, externalized denial, internalized attackers, avoiders, and deniers.

Comment: The authors of this paper promote environmental modifications in the classroom based on the results of a coping assessment instrument.

Treatment Strategies

Kazdin, A.E. (1987). Current treatment. In A.E. Kazdin (Ed.) *Conduct disorders in childhood and adolescence* (pp. 73-95). Newbury Park, CA.: Sage Publications.

Synopsis: Many types of treatments are currently available for children with conduct behavior problems. This chapter is a description of the range of treatment approaches.

A wide range of treatment approaches can be viewed in two ways. First, it is a sign that the field is not rigidly set on one or two techniques. On the other hand, it also suggests that no particular approach has been shown to ameliorate antisocial behavior. According to Kazdin, four techniques appear to be promising: parent management training, functional family therapy, problem-solving skills training, and community-based treatment.

Parent management training includes procedures to teach parents how to interact differently with their child so that prosocial rather than coercive behaviors are directly supported and reinforced in the family. Some common characteristics of various types of parent management training are: 1) treatment is conducted primarily with the parents who then implement procedures in the home; 2) parents are trained to identify problems in specific ways; 3) sessions cover social learning principles and procedures (positive reinforcement, mild punishment, negotiation, contingency contracting, etc.); and 4) parents practice techniques through modeling, role play and rehearsal. Outcome studies of parent management training have shown good results. Factors that contribute to outcome are: 1) protracted or time unlimited duration; 2) in-depth coverage of social learning principles; 3) therapist training and skills; 4) family functioning; and 5) support system of the mother. Limitations are that families may not respond to treatment, the approach is demanding of parents, and it is not a viable option when parents are unavailable.

Functional family therapy emphasizes systems theory and behavioralism and views interaction patterns from a broader perspective than parent management training. The goal of treatment is to improve communication and support functions within the family. Family members meet with a therapist, read a manual that describes behavioral principles, and explore alternative ways of viewing problems. Outcome studies indicate that functional family therapy shows promise; effectiveness is influenced by the relationship and structuring skills of the therapist. Client-centered and psychodynamically oriented family-based therapies have not proved as successful as functional family therapy.

Cognitive problem-solving skills training "focuses on the child's cognitive processes (perceptions, self statements, attributions, expectations, and problem-solving skills) that are presumed to underlie maladaptive behavior." The assumption is that aggression is triggered by environmental events that are perceived and processed inappropriately. Behavioral adjustment is related to problem-solving steps that include alternative solution thinking, means-end thinking, consequential thinking, causal thinking, and sensitivity to interpersonal problems. The variety of problem-solving skills training techniques share certain characteristics: 1) an emphasis on how a child approaches situations with a focus on the thought processes rather than on specific acts; 2) a step-by-step approach to solve problems; 3) structured tasks; 4) an active role of the therapist including modeling, feedback and praise; and 5) treatment combined with different procedures including role-play, reinforcement, and mild punishment. Outcome studies have generally focused on the impact of training on cognitive processes rather than on deviant behavior. Kazdin views cognitive problem solving skills training as promising because it: 1) is tied to theory and research in developmental psychology; 2) developmental differences need to be considered in designing effective treatment; 3) can produce change in children with mild adjustment problems; and 4) variations of the approach are available in manuals. Limitations are that specific cognitive deficits have not been related to particular dysfunctions, and studies have not indicated that the application of treatment was related to the impairment.

Community-based treatments refer to an approach that assumes that treatment conducted in the community takes advantage of the resources in the everyday environment that can support prosocial behavior. This approach integrates and treats antisocial youth and prosocial peers together. Various treatment techniques are integrated with community programs. Outcome studies are rare and difficult to interpret because of the complexity of the variables and the number of questions left unanswered.

The author proposes some alternative ways of looking at treatment of conduct disorders. One is to view it as one would a chronic disease because of its broad impact during both childhood and adulthood and because of the variety of therapeutic procedures that can be used to produce change. As Kazdin states, the "chronic disease model points to the need for continued care and monitoring of functioning until the time that a better, more abbreviated, and more effective intervention is developed."

Comment: This book gives a comprehensive and straightforward view of conduct disorders, of promising treatment approaches, and of research and evaluation issues and problems.

Treatment Strategies

Kendall, P.C. & Braswell, L. (1985). Treatment: The basic ingredients. In P.C. Kendall & L. Braswell (Eds.) *Cognitive-behavioral therapy for impulsive children* (pp. 115-142). New York: The Guilford Press.

Synopsis: This chapter is a description of the separate strategies of cognitive-behavioral interactions with children who are impulsive.

The main strategies for cognitive-behavioral self-control therapy include: 1) a problem-solving approach; 2) self-instructional training; 3) behavioral contingencies; 4) modeling; 5) affective education; and 6) role-playing. An underlying theme to all the strategies is one of problem solving both impersonal tasks and interpersonal problems. Problem-solving skills are valuable for adjustment and involve cognitive strategies to consider courses of action. As the authors state, ". . . interventions are best focused not on teaching specific responses but on *training the cognitive processes* involved in problem solving."

An effective way to solve problems is through self-instructional training that involves creating sentences to define the problem, approach the problem, focus attention, choose an answer, and self reinforce or (in the case of choosing an incorrect answer) cope. The children put the sentences into their own words; the self-directed statements should be individualized. The sequence of self-instructional procedures include: 1) therapist models task performance and talks out loud while the child observes; 2) the child performs the task, instructing himself/herself out loud; 3) the therapist models task performance while whispering the self instructions; 4) the therapist performs the task using covert thinking; and 5) the child performs the task using covert self-instructions.

Incentive manipulation and the use of contingencies are essential features of the training. Self rewards and social rewards should be encouraged. Response-cost contingency involves tokens that can be lost for various reasons. This approach should not be regarded as entirely punitive but also as a cue for the child to slow down and improve behavior next time. Teaching self-evaluation skills helps a child maintain desirable behavior after contingencies are removed.

Modeling is used to expose the child to self-instruction skills and to learn how to cope. "A model who self-verbalizes is superior to one who does not verbalize." The training also includes improving children's abilities to recognize and name emotional experiences. This "affective education" can occur during role-play or self instructional training. Role playing can be arranged for both hypothetical situations and for actual problem situations. It is wise to begin with the hypothetical to let children get used to role play. During role play, children are encouraged to use the steps they have learned to solve problems.

The authors state, "The actual tasks used in training are quite unimportant relative to the method of task approach that is being taught." However, they offer some advice on the nature and sequence of tasks that appear to contribute to the effectiveness of training. They recommend a progression from impersonal, cognitive tasks to more interpersonal emotional material. The chapter includes sample dialogues between therapist and a child.

Comment: This chapter is helpful in explaining the theory and practice of cognitive-behavioral therapy.

Treatment Strategies

Kramer, D.A., Anderson, R.B. & Westman, J.C. (1984). The corrective autistic experience: An application of the models of Tinbergen and Mahler. *Child Psychiatry and Human Development*, *15*(2), 101-20.

Synopsis: This article is a description of a treatment model for children with autism that focuses on their social and interpersonal lives.

The authors describe a treatment approach, proposed by Niko and Elizabeth Tinbergen, in the area of social behavior and interpersonal relationships of children who have autism. This model has three elements. The first is a decreased tendency in these children to approach and an increased tendency to withdraw in social situations. The Tinbergens attributed this withdrawal behavior to fear. The second element is that all of the behavior patterns seen in children who have autism also occur in normal children; the difference is quantitative. The third Tinbergen observation is that children with autism have the capacity to engage in approach (rather than withdrawal) behavior indistinguishable from that of normal children; here, too, the difference is quantitative. The Tinbergens propose that there is a continuum between normal and autistic behavior in children.

In implementing the model, the authors of this article made five observations. First, in the playroom situation, the therapist is very careful to be non-intrusive by not looking at or initiating touching the child. This non-intrustive interaction is to avoid stimulating withdrawal behavior on the part of the child. Secondly, the therapist observed approach behavior patterns such as eye contact, decrease in physical space between the child and therapist, any physical contact, and increased verbalization. The third aspect of implementation is the mirrored response of the therapist to the child's approach behavior. The therapist responds in the same mode and with the same intensity as the child. The fourth element of implementation relates to the therapist's mirroring reaction to the child's withdrawal and bizarre behaviors. Lastly, the child with autism progresses from primarily negative social behaviors to mostly mid-level and positive social behaviors gradually during a therapy session.

The intervention was tried with ten children with autism. Because other treatments (speech therapy, parent training, behavior modification programs, and special education programs) were occurring at the same time as this one, it was difficult to evaluate. However, the authors believe that attention to social interaction behaviors in the way described above adds to the abilities gained in the other interventions. The article includes a case example.

The authors have combined some of the theories of Margaret Mahler with those of Tinbergen to develop their approach to treating children with autism. Mahler suggests that children can be lured out of their autistic shells; she called this "corrective symbiotic experience." This is adapted by adding the approach suggested by the Tinbergens that encourages the therapist to await the child's approaches; they call this "corrective autistic experience."

Comment: Although this article is quite academic and may be limited to the condition of autism, the therapeutic approach is an interesting one that might be adaptable to other disabling conditions.

Levy, L.P. (1982). The integration of the foster grandparent program with an acute care psychiatric service. *Social Work in Health Care*, *8*(1), 27-35.

Synopsis: This article is a description of an effort to involve the Foster Grandparent program in a psychiatric hospital, the problems encountered, and the contributions to treatment.

The Foster Grandparent Program is a federal effort to bring older people together with children living away from home and family. Foster grandparents work in residences and institutions four hours a day, five days a week, receive a stipend, and are trained and supervised by staff at the site. Their task is to provide a warm, interested relationship for each child. The psychiatric hospital described in this article is mandated as the receiving hospital for children needing acute psychiatric hospital care. The hospital consists of three locked wards, one for children 3 to 12, and two adolescent wards, one male and one female. The emphasis is on evaluation and treatment planning with stays of one to two months. The patient population is heterogeneous, both ethnically and clinically, but all patients have a need for positive emotional involvement. The staff did not have the time necessary to provide the kind of attention these children needed. This was the rationale for the introduction of foster grandparents.

The initial problem was concerned with which professional discipline would supervise the grandparents. Ultimately the Department of Social Work Services was assigned this responsibility. Three foster grandparents were recruited, one for each ward. Initially no one knew what to do with them and conflicts arose. The multidisciplinary team met to deal with problems related to implementation of the program. Goals became more realistic as the program progressed. After a year, both the staff and the foster grandparents knew what to expect from each other. As the author states, "The foster grandmothers have become active members on multidisciplinary teams, participating in ward conferences, sharing with staff their observations of patients, and contributing to patients' treatment."

Comment: This approach of using an informal resource in service planning and treatment is relevant to Therapeutic Case Advocacy.

Treatment Strategies

*Lockwood, J.L. (1981). Treatment of disturbed children in verbal and experiential group psychotherapy. *International Journal of Group Psychotherapy, 31*(3), 355-366.

Synopsis: This article is a description of a follow-up study designed to assess the adjustment of children who participated in group psychotherapy.

The subjects of the study described in this article were twenty-five children, aged nine to thirteen, selected randomly from a pool of 111 outpatients who had participated in group psychotherapy. The children were divided into two groups--one nine and ten year olds and one for children eleven to thirteen. The children participated in group therapy sessions for from two to twenty-four months. Follow-up occurred at least six months after termination of therapy.

Therapy groups had co-therapists and both groups concentrated on alternative problem solving techniques. Practice consisted of role-playing, psychodrama, and real-life interactions with one another. The author explains, "A basic goal for the group was that of modifying and expanding the children's usual modes of problem-solving; the primary related therapeutic experiences were those of discussion, which focused on the identification and labeling of problems and attendant feelings, and practice in attacking and responding to the identified problem in ways that would most nearly mimic the *in vivo* situation."

During follow-up children were rated as unimproved, moderately improved, or much improved by parents, school personnel, and the co-therapists. Data were obtained by a standardized interview, that assessed changes in symptoms, appearance of new symptoms, overall adjustment, school performance, and social behavior. Only 3 children were rated unimproved by parents, school personnel, and therapists, and three additional children were assessed as moderately improved by parents and school personnel and unimproved by the therapists. In all, 88 percent were rated as much improved by parents, 83 percent by school personnel, and 76 percent by the group therapists. All six who were rated unimproved by therapists attended less than 13 sessions. There were no significant differences with respect to age or sex among improvement categories. Two factors were common to those who improved: 1) children attended twenty-five or more sessions over a minimum six-month period; and 2) their families were interested and involved in therapy.

The author concludes that these findings suggest that group therapy is an effective form of treatment for latency-age children and that cognitive, verbal aspects of group therapy are appropriate aspects of treatment for that age group. She urges others to conduct studies using more stringent techniques.

Comment: The unique aspect of this article is the use of group therapy techniques with latency-aged children who have emotional disorders.

Margolin, L. (1983). A treatment model for the adolescent sex offender. *Journal of Offender Counseling, Services, and Rehabilitation*, 8(1/2), 1-12.

Synopsis: This article includes a definition of the adolescent sex offender and a description of a treatment program that emphasizes the functions of labeling, group therapy, and structured living environment.

The author takes the position that youth who commit sex offenses display behavioral and personality characteristics that require treatment to help them develop a new set of social norms. The "hands on" adolescent sex offender is one who has coerced a sexual act that involves direct physical contact between the offender and victim, usually rape and child molestation. These adolescents were found to be different from other hospitalized adolescents. Margolin states that these youth are outwardly cooperative in treatment programs but are usually manipulative and sneaky. They have a need to control others, have a proclivity to lie, and often were abused themselves. She concludes, "The lying and manipulative behavior he shows is frequently a product of a very careful matching of means to ends, which suggests that his problem is not medical, but social, educational, and moral in nature."

The treatment program described in this article includes the planned use of ambiguity, directed peer interaction, and an attempt to generalize beliefs beyond the program. If the offender's attempts to control others is always thwarted, he will feel ambiguity. In the treatment setting, instead of being praised for being a "good boy," he is labeled as an "HRO"--High Risk Offender. This is aversive to him and is met with strong resistance. This labeling is perhaps the most controversial part of the program. However, the label deprives the offender of the ability to retreat, to put on a front, or to push his offenses to the back of his mind. The tight schedule of the ward program is designed to minimize the adolescents' capacity to control others. They are placed in isolation when they participate, or are even suspected of participating, in controlling behavior (intimidation, lying, extortion, etc.).

To generalize beliefs (such as paying attention to peers, and understanding and caring for them) repetitive testing and practicing is required. This is accomplished by four to six hours a week of group therapy. Groups have four to nine adolescents with two leaders, at least one of whom is female. The leaders "force" the members to remain on task, to pay attention to and understand each other, and to recognize how they have hurt others. Noncompliance in the group can result in time in isolation, a more restrictive schedule, and fewer home visits and later discharge.

Since this population is usually manipulative, they soon learn to say the right things. It is the leaders' responsibility to expose dishonest comments. Leaders need to look for contradictory statements, absence of spontaneity, body language, eye contact, and negative affect. The analysis of dishonesty invites the involvement of other group members. They question each other because they are alike. Once someone admits his dishonesty, he is praised by the leaders. This honesty is explained as a demonstration of his trust and caring for other members. The author feels, "A minimum of one and a half to two years is required before the internalization of a new normative structure can be anticipated."

Comment: Margolin does not claim that this is the only approach that has value for this population, but that it is one that has received little attention. It can be used in conjunction with other more traditional approaches.

Marotz, B. (1983, April). *Improving the social acceptability of emotionally disturbed children.* In Conference Proceedings of "Meeting Their Needs: Provision of Services to the Severely Emotionally Disturbed and Autistic." Memphis, TN (ERIC Document Reproduction Service No. 244 457).

Synopsis: This presentation is an exploration of the assessment and intervention strategies concerning social interaction skills with children who have emotional disorders.

Improving social skills and acceptability infrequently are given sufficient attention in educational programming for children with emotional problems. Assessment of social skills and acceptability must precede intervention. Assessment tools would include teacher ratings, sociometric ratings, direct observation, and a look at others in the student's environment.

Intervention strategies fall into three categories: 1) those aimed at changes in the classmates of the student who have an emotional disability; 2) those aimed at changing teaching strategies; and 3) those focusing on the students with emotional problems themselves. Strategies involving regular classmates include: 1) group meetings to teach awareness of feelings, fairness, and what it means to be in a relationship; 2) a buddy system, especially for withdrawn students; 3) grouping students for projects and classroom activities based on the sociometric choices of the child with emotional problems; and 4) compliment games where the goal is for students to learn to support one another by giving legitimate compliments to each other.

Some teaching tactics include: 1) descriptive praise that tells students exactly what they are doing well; 2) group rewards; 3) peer tutoring; and 4) modeling acceptance of the child with problems so other students will develop similar acceptance. In regard to the student with emotional disabilities, some possible interventions may be: 1) specific skills training involving modeling and behavioral rehearsal; 2) a hero procedure whereby students earn rewards not only for themselves but for others; 3) a technique for students who are frequently teased and then overreact that involves scheduled teasing in a controlled and safe setting; 4) feedback on social performance; 5) training in a play activity; 6) counseling individually or in a group; and 7) interaction with younger students.

The author does not suggest that changing the social ability or acceptability of a child with emotional problems is easy. Rather, she stresses that it is important and often necessary for other learning to occur.

Comment: This article is a description of some specific strategies to help a child learn social skills and to modify the child's environment.

Treatment Strategies

*Matson, J.L., Esveldt-Dawson, K., Andrasik, F., Ollendick, T.H., Petti, T. & Hersen, M. (1980). Direct observational and generalization effects of social skills training with emotionally disturbed children. *Behavior Therapy, 11*(4), 522-531.

Synopsis: This article is a description of a small study of four children who were hospitalized and subsequently treated for social skills deficits.

Social skills training includes instruction, modeling, role playing, information feedback, and social reinforcement. The study reported here "(a) tested the vicarious learning effects that accrue from social skills training, (b) assessed the degree to which 'booster sessions' enhance maintenance of conventional social skills training with some previously untreated childhood problems, (c) assessed generalization effects of observational learning and active social skills training, and (d) included the initial evaluation of consumer impressions of social skills training."

The subjects of the study were four inpatients (nine and eleven years old) in a short-term treatment unit for children who have emotional disorders and learning disabilities. All four had trouble adapting at school and home and were described as antisocial and withdrawn. They all exhibited deficits in rudimentary skills necessary for successful social adjustment. Two children were classified as borderline mentally retarded while two were classified as above average.

Social skills were assessed on the basis of the children's responses to scenarios acted out by the child and co-therapist. The children also responded to a consumer questionnaire. They were scored on appropriate verbal content (giving compliments, giving help, and making appropriate requests), appropriate affect, appropriate eye contact; and appropriate body posture. Data were collected before training, during training or observational learning, during booster sessions, and at follow-up fifteen weeks after training. Training occurred in a group setting lasting thirty minutes per session.

All four children showed an increase in positive social behaviors in both training sessions and in generalized ward situations. Maintenance of gains was evident at follow-up with or without booster sessions. Observation of training did not contribute greatly in acquisition of the targeted skills.

Comment: Although this study included a small sample of children, the results were encouraging.

Treatment Strategies

McAdam, E.K. (1987). Cognitive behaviour therapy: A therapy for the troubled adolescent. In J.C. Coleman (Ed.), *Working with troubled adolescents* (pp. 123-137). London: Academic Press.

Synopsis: This chapter is a description of cognitive psychotherapies adapted for the treatment of emotional disorders in adolescents.

Cognitive therapies are based on the assumption that people interpret their environment according to their own sets of values, beliefs, expectations, and attitudes. These interpretations color the views people have of themselves in their world, which in turn influences moods and behaviors. The author states, "Cognitive therapists would argue that cognitive interpretation influences the individual's physiological response to a situation and has behaviour and emotions within that situation." Thus, cognitive behavioral therapy uncovers and changes those aspects that influence cognitive interpretation in maladaptive ways. Three examples of cognitive errors are: 1) minimizing or distorting evidence so a positive achievement is not fully recognized; 2) personalizing or blaming oneself for another's behavior without justification; and 3) dichotomous, absolute thinking whereby everything is black or white and the extreme negative view prevails.

The therapist is very active when using a cognitive approach -- asking questions, summarizing, getting feedback, and promoting alternative responses. With adolescents, the therapist accepts their perspective regardless of how distorted or unrealistic it may be. Some strategies of working with adolescents are: 1) set an agenda to deal with one problem at a time; 2) identify target problems; 3) gather data and break problems down into smaller parts; 4) summarize the problem using the adolescent's own words; 5) provide feedback and reframe the problem if necessary; and 6) assign homework so the adolescents can sort out their own difficulties and feel in control.

In the therapeutic process there are four strategies employed: 1) monitoring of automatic thoughts by asking questions, using imagery, and role playing; 2) generating alternative ideas through distancing, role reversal, depersonalization, and collaborative empiricism (making a belief into a hypothesis and then testing it); 3) recognizing the connection between automatic thoughts, affect, and behavior; and 4) modifying cognitive errors through a sequence of neutrality, gentle humor, and collaborative empiricism.

The author feels cognitive behavioral therapy can be used successfully with adolescents because it utilizes the natural developing cognitive skills of these youngsters. It is important that assessment determines the ability of the youth to think operationally and abstractly.

Comment: McAdam offers very concrete and practical strategies for working cognitively with adolescents through the use of case examples.

*Newman, R.K. & Simpson, R. L. (1983). Modifying the least restrictive environment to facilitate the integration of severely emotionally disturbed children and youth. *Behavioral Disorders*, *8*(2), 103-12.

Synopsis: This article is a discussion of modifying the attitudes of regular class students to facilitate the integration of students with severe emotional problems into regular classrooms.

Little attention has been given to preparing the least restrictive educational environment to accommodate children with serious disabling conditions. This is especially true with regard to methods to positively modify attitudes of regular class students toward children who have emotional disorders. The study described in this article was designed to look at the effects of providing children information about and experiences with students with emotional disabilities.

The three research questions were: 1) To what extent does providing children in regular education information about and experiences with the disabled influence their interactions with pupils who have severe emotional disorders? 2) To what extent does the sex of the regular class pupils affect their behavior toward the disabled? and 3) To what extent does the grade level of regular class pupils influence their behavior toward the disabled?

Regular classroom students in grades one to six took part in the information portion of the project which consisted of six half-hour sessions in each room. This included a presentation of facts and discussion about: 1) the concept of exceptionality; 2) common disabling conditions; 3) similarities and differences between regular and special education students; 4) appropriate ways of interacting with special education students; 5) curricula and procedures used in educating disabled children; and 6) famous persons who have had to contend with a disabling condition. The students were also provided direct information about the students with severe emotional disorders in their school. Half of the classes at each grade level then had structured experiences with the pupils with severe emotional disorders in the special education classroom. These activities included playing games and engaging in music and art classes with the students in the special education class.

The results indicate that those students who received the information only portion of the project initiated more positive contacts with the pupils with emotional disabilities than did those who were also provided the structured interaction activities. Also, females and students in the lower grades were most responsive to the students with disabled. The authors conclude, "The intervention with students in regular classrooms may be a necessary and efficacious part of successfully integrating severely emotionally disturbed pupils into public school settings."

Comment: These authors offer a unique approach to changing the classroom environment rather than emphasizing change in the child with the disabling condition.

Treatment Strategies

O'Leary, K. D. (1980). Pills or skills for hyperactive children. *Journal of Applied Behavior Analysis, 13*(1), 191-204.

Synopsis: This article is a comparison of the short-term effects of psychostimulant medication and behavior therapy on the social and academic behavior of children who are hyperactive.

The author discusses the debate between advocates of psychostimulant therapy with children who are hyperactive and behavioral therapy with this population. Research has established that, on the basis of teacher ratings, psychostimulants effect cooperation, attention, and compliance. Behavioral therapy with an emphasis on reinforcement of classroom behavior, teacher consultation, and parent consultation has a positive effect on attention levels, completion of assignments, cooperation with peers, and disruptiveness.

In relation to academic behavior, the research has not proven the efficacy of long-term psychostimulant therapy on academic achievement. With behavior therapy, academic production rates have increased, but no long-term research has been conducted. Self-instruction training appears to influence impulsive behavior on laboratory tasks, but its contribution to overall academic achievement of children who are hyperactive is not clear. The author states, however, "Given that daily and weekly assignment completion have increased with behavioral programs for hyperactive children, given that improvements on standardized achievement tests have occurred with self-instruction, and given that we have found changes on standardized tests with children labeled conduct disordered, it seems very likely that a behavioral treatment for hyperactive children could lead to long-range academic and social changes."

The sole use of psychostimulant therapy is increasingly questioned. Because behavioral therapy approaches have shown promise, the author urges their use as a first alternative. Some children may need a combination of both psychostimulants and behavioral therapy at some times. One danger of psychostimulant therapy alone is that it can be viewed as a panacea to control irritating behaviors. The author stresses that long-term research with multiple dependent measures is critical to address many of the issues involved with drug versus behavioral therapies. Emphasis should be placed on: 1) academic changes as assessed by teacher ratings and standardized achievement tests; 2) family changes as assessed by after school ratings and observations and assessment of marital discord and family discord; 3) detailed cost analysis of treatment programs; and 4) consumer satisfaction with the treatments (e.g., child, parent, teacher, and tutor).

Comment: This author provides a nice overview of the controversy involving treatment strategies for children who are hyperactive.

Patton, P.L. (1985). A model for teaching rational behavior skills to emotionally disturbed youth in a public school setting. *The School Counselor, 32*(5), 381-87.

Synopsis: This article is an exploration of the use of rational behavior therapy to assist youth who have emotional disorders to acquire rational behavior skills.

Patton reports on a study to test the efficacy of rational behavior therapy used with an experimental group of adolescents in an alternative public school setting. The training model (based on the work of Maxie Maultsby, Jr.) consisted of five training techniques. The *first* is to teach the goals of rational behavior therapy. Secondary goals are to achieve maximum independence from neurotic needs, desires, and support of others; acceptance of the individual of responsibility for desired behavior change; self-determination of goals and values in life; freedom from poorly controlled reactions to stress; and unqualified acceptance by each person of his or her unavoidable fallibility. These ideas were taught in didactic presentations and through group discussion.

The *second* technique was to teach the five basic criteria for rational thinking. The questions ask whether rational behavior: 1) Is based on objective reality? 2) Is life-preserving? 3) Is likely to assist in reaching short and long-term goals? 4) Prevents significant personal emotional conflict? and 5) Prevents significant conflict with other people and the environment? Again, the methods used to convey these ideas were didactic presentation and group discussion. Students were asked to begin evaluating their behavior based on these criteria.

The *third* technique was teaching each student the anatomy of an emotion. Students broke down each emotion into three parts: 1) facts and events (perceptions); 2) self-talk (evaluating thoughts); and 3) feeling (emotional/behavioral response). In addition to a presentation and discussion, students performed exercises to practice breaking down emotions.

The *fourth* technique was to teach the understanding and use of rational self-analysis. Rational self-analysis is based on six parts that include writing down the facts of an event, double checking to make sure the description is factual and not subjective, writing down an evaluation of the same event, challenging the subjective evaluations, writing down the feelings associated with the event, and lastly, writing down a more appropriate, rational feeling in response to the event.

The *fifth* technique was to teach the use of rational emotive imagery. This involved repeated use of rational self-analysis and then imagining oneself in a situation that leads to problem behavior, both in a negative and positive way. Once performing imagery was learned, students were asked to practice this for 10 minutes every day.

The experimental group met for ten weeks of three forty-minute sessions each week. The students were constantly reinforced for attendance, completing tasks, and exhibiting rational thinking and behavior. The results of pre-and post-tests and control group comparison revealed that "training was effective in influencing learning of rational concepts and influencing the ability to generalize the concepts into personality structures. The training did not, however, seem to effect overt behaviors manifested in the educational milieu."

Comment: Patton suggests the need for further research and for possible modification in the training methods; the model as presented in this article is complex.

Treatment Strategies

Pfeffer, C.R. (1980). Psychiatric hospital treatment of assaultive homicidal children. *American Journal of Psychotherapy, 34*(2), 197-207.

Synopsis: Hospitalization is often the best first phase of treatment for children with homicidal behavior.

The spectrum of homicidal behavior includes: 1) homicidal ideation (thoughts of wanting to kill or harm someone); 2) homicidal threats; 3) homicidal attempts; and 4) homicide. Hospitalization for children who are assaultive and homicidal is often required to contain and redirect homicidal impulses. Physical holding or isolation often is beneficial to defuse the intensity or eruption of uncontrolled aggressive impulses. This may be used in combination with medication. When children realize they are taken seriously, they are more willing to talk about their feelings.

Hospital treatment includes a variety of interventions such as individual, group, and family therapy, school remediation, and psychopharmacology. The hospital milieu offers structure, supports, constancy, protection, and opportunities for transference reactions. The author states, "Recognition that the behavior of the assaultive child who is demanding, provocative, and hostile is a reenactment of his vulnerability, helplessness, and distress derived from conflicts with significant family members is a vital factor in hospital therapy."

In individual therapy, immediate goals of intervention are channeling aggressive impulses into play elaboration and verbal communication. The therapist must promote an empathic, inquisitive, and objectively neutral attitude. After these initial objectives are achieved therapeutic strategies should be more individualized, depending on the background and age of the child.

The last half of this article presents a series of case vignettes that include various examples of therapeutic interventions. The author concludes that in most instances therapy is long-term and "the main goals of hospitalization are to strengthen ego functioning and to work through conflictual issues for the child and his family."

Comment: This article, which is very psychoanalytical, is an exploration of ways of working with children who have an extreme disturbance.

Treatment Strategies

Ranieri, D.J. (1984). Motivating institutionalized adolescents for psychotherapy. *Adolescence*, *29*(76), 925-933.

Synopsis: This article is a discussion of a review of the literature on motivating institutionalized adolescents for psychotherapy and offers recommendations on how to motivate these clients.

Often institutionalized adolescents are viewed as untreatable cases who are frustrating and draining. Ranieri reviewed the literature on client motivation to lay a foundation for a program to increase the motivation and participation in psychotherapy for institutionalized adolescents. This review revealed that people are not motivated if they do not find their situation intolerable, if they feel accepting help is a sign of weakness, or if the costs of treatment exceed the benefits.

The author presented his program to motivate adolescents at two levels--1) pretherapy (up to and including intake interview) and 2) during institutionalization. Pretherapy serves the purpose of enabling the treatment facility to gather information on the adolescent as well as allowing the adolescent to find out about the facility. Staff at the facility should assess the adolescent's preferences regarding psychotherapy as well as preparing the adolescent for treatment. A major focus of the intake interview should be to become aware of and try to define the areas of distress within the adolescent. It is also important to communicate concern and interest. The adolescent should know what to expect and what is expected.

Once inside the institution motivation is based on a token economy--a system of rewarding or withdrawing tokens. The tokens can be exchanged for privileges, an allowance, and other things especially rewarding to the adolescent. Opportunities to earn tokens should be limitless and the choice of behavior be left up to the adolescent. The system should work toward target behavior changes that are chosen for each adolescent individually. Anything that leads to client satisfaction without decreasing the effectiveness of the program should be implemented.

Ranieri describes the foundation of an approach to increase adolescent motivation for psychotherapy. The next step would be to implement and evaluate such a program.

Comment: This article is a description of a behavioral approach to get adolescents involved in psychotherapy.

Treatment Strategies

Raubolt, R.R. (1983). Brief, problem-focused group psychotherapy with adolescents. *American Journal of Orthopsychiatry, 53*(1), 157-65.

Synopsis: This article is a discussion of the practical issues and treatment considerations in brief, problem-focused group therapy with adolescents.

The author proposes an integrative group therapy model that places importance on both activity and insight while recognizing brief group psychotherapy. The advantages of a brief therapy approach are: 1) an opportunity for more extensive evaluation of the adolescent through observation of group behavior; 2) emotional peer support for confronting and working through conflicts; 3) a setting to rehearse new behaviors and attitudes; 4) fulfillment of the adolescent need for action; 5) helpfulness of peer associations in establishing independence and autonomy, as well as recognizing individual differences; and 6) dilution of the transference with the adult leader.

Proper selection of group members is crucial in brief therapy because of the time-limited format. Certain adolescents are excluded: 1) sociopathic or severe characterological disorders because of lack of motivation; 2) severely narcissistic adolescents because they are unable to engage in the give and take process; 3) active psychotics because they are disruptive and provoke anxiety and anger; and 4) brain damaged or mentally retarded who cannot communicate verbally. The adolescents who seem to do well in a brief group format are those with adjustment disorders, neuroses, delinquency, and are emotionally disengaged from parents. Members are interviewed before group sessions begin to discuss rules: understanding each other; confidentiality; putting feelings into words; and no acting out or aggressive behavior. Members must make a therapeutic group contract with a specific goal that represents a desired behavioral change.

The therapist plays an active role, creates an atmosphere that encourages direct and open emotional sharing, provides support, shows vulnerability when appropriate, and serves as a model. Two strategies are effective. The first is "direct encountering" which offers members the opportunity to connect insight with action, to challenge fears and limitations and to develop self esteem. The therapist provokes, guides, challenges, and teaches. The second strategy is "indirect encountering" which is appropriate when an adolescent is anxious or threatened. This strategy, which includes a variety of paradoxical approaches, should be used carefully and not without thorough assessment and understanding of resistances.

Comment: This article is relevant to those engaged in group work with adolescents. It is specific and practical.

Raubolt, R.R. (1983). Treating children in residential group psychotherapy. *Child Welfare, 62*(2), 147-155.

Synopsis: This article is a description of the hazards and benefits of using group psychotherapy with children in residential treatment.

Group psychotherapy with children has received little attention from professionals. Raubolt offers two explanations for this phenomena. First, group psychotherapy with children is difficult and demanding. The author states, "In essence, the group therapist working with children has to be tolerant of intense emotion; comfortable with nonverbal modes of interaction, that is, play and activities; and cognizant of the need to set limits to behavior." Second, historically group therapy for many years was synonomous with activity group therapy with an approach of "unconditional love." The child was "fully accepted, including his/her destructiveness, aggressiveness, and longings." The limitations of group activity therapy are that groups must be balanced to provide checks and balances, and the course of treatment is lengthy, often up to three years. Raubolt feels that activity group therapy will remain a small specialty area within the larger area of group therapy.

The approach discussed in this article is residential group therapy with children who are impulse-disordered. The children the author works with are angry and aggressive, with destructive behaviors. Seventy percent of them have been physically or sexually abused; their most common diagnosis is conduct disorder, undersocialized, aggressive. The children range in age from five to eleven, and, for the most part, have had few nurturing figures in their lives.

Raubolt feels that, "the selection of members for group therapy in many ways determines the eventual success or failure of the group." He states that one effective selection measure is homogeneous groupings based on styles of interaction rather than problem behavior. Traditional group psychotherapy approaches are usually ineffective with children who are impulsive and aggressive. They need protective limits to help provide a sense of security and a decrease in anxiety.

Two specific strategies found to be effective with these children are individual contracts that focus on specific behaviors and the use of time outs. Rules need to be established such as no fighting or breaking materials. Time out in the group setting means returning to seats, sitting quietly, closing eyes, and becoming aware of muscle tension. The therapist guides the children through this procedure and a subsequent relaxation exercise. The reason for the time-out is then calmly discussed.

A modified play group approach is used involving both solitary and group play. Materials are selected based on their effectiveness in reducing aggression and providing an opportunity for ego mastery. Materials include balls, darts, checkers, chalk, clay, markers, and paper.

The therapist's role is multifaceted: protector, alter-ego, interpreter, and provider of snacks. The therapist's responsibility is to introduce verbal exchange in small doses. "The therapist is required to operate as a benevolent authority."

Comment: The author provides specific and practical suggestions to a therapist considering group therapy with children (as opposed to adolescents).

Treatment Strategies

Rinsley, D.B. (1980). Diagnosis and treatment of borderline and narcissistic children and adolescents. *Bulletin of the Menninger Clinic*, *44*(2), 147-170.

Synopsis: This article is a discussion of the etiology of borderline and narcissistic disorders and treatment modalities.

Rinsley describes children with borderline disorder as lacking identity or sense of self, or more accurately, as having a pseudo-identity. Treatment can occur in either residential or outpatient settings. Residential treatment should be highly selective and reserved for those children and adolescents who: 1) exhibit symptomatology, behavior, or conduct that is seriously disruptive or bizarre; 2) cannot utilize home, school, church, and other growth-supportive adults and institutions; 3) exhibit progressive psychosocial deterioration that persists despite all efforts to arrest or remit it; and 4) have "parental-familial pathology" that necessitates removal from a clearly dysfunctional, pathogenic family.

Rinsley feels that regardless of the setting, individual psychotherapy is necessary for the adequate treatment of children with borderline and narcissistic disorders. The dynamic psychotherapy includes three stages: 1) resistance stage; 2) an introjection or definitive (working through) stage; and 3) a resolution (separation) stage. The basic task of the resistance stage is the generation of mutual trust so the therapist can become aware of the child's inner world. The working through phase involves insightful exposure and interpretation of the child's defenses and need to remain dependent. As the defenses are revealed, separation and individuation begin. This occurs during the resolution stage.

In a majority of instances, individual therapy must be accompanied by family therapy. The author feels that, "...a significant aspect of family therapy is the therapist's ability to re-parent the parents."

Comment: This article is a presentation of a psychodynamic approach to treatment in a straightforward manner.

Scheidlinger, S. (1985). Group treatment of adolescents: An overview. *American Journal of Orthopsychiatry*, *55*(1), 102-11.

Synopsis: This article is a description of four categories of group intervention with adolescents.

The author suggests classifying the types of groups used with adolescents as: group psychotherapy, "therapeutic" groups, human development and training groups, and self-help and mutual help groups. *Group psychotherapy* refers to a psychosocial process with a trained mental health professional who uses emotional interaction in small, carefully constructed groups. Each group member has a diagnostic assessment. The group is balanced with attention to age, sex, sophistication level, intelligence, and personality style. Therapists need to be trained in the group process system and group psychotherapy.

"Therapeutic" groups are usually an adjunct to a larger treatment program. *Human development and training groups* are geared more to the realm of affective and cognitive education than to therapy. *Self-help and mutual help groups* are voluntary meetings for mutual aid around a general purpose.

The author admits that boundaries between the four types of groups are not clearly delineated, but he feels the classification is preferable to utter confusion. The bulk of the article focuses on group psychotherapy for adolescents.

Group psychotherapy with adolescents is practical in nature, that is to supplement psychoanalytic techniques with guidance and education. In the author's opinion, there are two reasons adolescent groups do not survive: 1) failure to achieve a desirable group balance; and 2) the mistaken assumption that training in individual psychotherapy also applies to group work. Adolescent groups are defensive in nature, and special skills are required to deal with this age group. It is advised that therapists see prospective groups members individually at least a few times before the group sessions to prepare them and to establish at least a minimal therapeutic alliance. Often peer interventions tend to carry more weight than those offered by the therapist. It is important that groups be flexible, honest, and direct.

The author feels strongly about the importance of group psychotherapy for adolescents. "Except for individuals with uniquely fragile egos, those in crises, sociopaths, overt sexual perverts, acute psychotics, and all paranoids, outpatient group psychotherapy is generally the treatment of choice for adolescents."

Comment: This article is relevant to those involved in group work with adolescents.

*Schleser, R., Meyers, A.W., Cohen, R. & Thackwray, D. (1983). Self-instruction interventions with non-self-controlled children: Effects of discovery versus faded rehearsal. *Journal of Consulting and Clinical Psychology*, *51*(6), 954-955.

Synopsis: This article is a description of a research project to evaluate self-instructional interventions used to improve the generalization of training effects with children who have little self-control.

The subjects in this study were forty-eight third and fourth grade children referred by teachers because of a problematic lack of self-control. The children were randomly assigned to each of four training conditions. These were: 1) a fading procedure group that received specific content instructions designed to provide an optimal strategy for successful performance on a math training task; 2) a general content fading group given a broad problem-solving strategy applicable to a variety of tasks; 3) a directed discovery group given specific content instructions whereby students were led through a question-and-answer Socratic dialogue with the leader to "discover" the strategy statements which were then rehearsed; and 4) a didactic control group. Children attended four forty-five minute sessions and were presented various sets of twenty, two-, three-, and four-place math addition problems.

Children in the directed discovery and specific fading conditions performed better on the math quiz than those in the didactic control group. On generalized measures, children in all three experimental groups performed better than those in the control group. Children in the discovery group were faster and more accurate following training. These same children showed the broadest range of generalization. The authors state that children in the directed discovery group were "taught how to think, not just what to think."

The results of this study should be interpreted cautiously; however, they point to the need for further exploration of directed discovery procedures.

Comment: The authors do not fully describe the procedures of the directed discovery technique.

Treatment Strategies

Sellers, J.M. (1981). Psychotherapy with the behaviorally disordered adolescent. *School Social Work Journal*, *5*(2), 69-74.

Synopsis: The author of this article attempts to integrate various approaches to working with adolescents who have behavioral disorders.

The author defines adolescents with behavior disorders as those who "display an inability to learn from experience, an inability to form normal interpersonal relationships, a tendency to develop somatic symptoms, higher non-verbal than verbal skills, educational neglect, inconsistent parenting, over-dependency on others, socioeconomic deprivation and an impulsive narcissistic affect." Some barriers to treating these adolescents that include weak ego strength, lack of motivation, resistance to change, fear of and lack of respect toward authority figures.

Sellers reviews the various therapeutic approaches used with this population. Since adolescents with behavior disorders have low frustration tolerance and lack coping mechanisms, roles and expectations need to be clearly defined in the therapeutic relationship. This helps build ego strength to help resolve conflicts between peer and family obligations. The adolescent can then begin to develop new roles and separate from family influences.

Some therapists feel strongly that parents and therapists must work together to determine the roles and obligations of each. Multidimensional approaches include educational and vocational services in addition to psychotherapeutic services.

Sellers believes that the current literature supports the need for multidisciplinary, individualized comprehensive approaches to work with adolescents with behavior disorders. He also states that no single approach has been "universally tried and proven."

Comment: The author presents various approaches to working with a specific population of adolescents.

Treatment Strategies

*Silver, L.B. & Brunstetter, R. W. (1986). Attention deficit disorder in adolescents. *Hospital and Community Psychiatry, 37*(6), 608-13.

Synopsis: This article is a discussion of the complexity involved in diagnosing attention deficit disorder in adolescents and the clinical management of the disorder.

Attention deficit disorder is characterized by "a failure to remain attentive in situations, especially in school and at home, where it is socially necessary to do so." Impulsivity is a behavior related to attention deficit disorder, and many adolescents develop secondary emotional problems because of the frustration and failure associated with this disorder. Attention deficit disorders are often associated with learning disabilities.

"The treatment of choice for attention deficit disorder is stimulant medication." Stimulants do not cure the disorder but appear to "assist the brain in compensating for what is believed to be a neurophysiological dysfunction." Follow-up studies seem to indicate that 80 percent of those with attention deficit disorder do not have problems after puberty. There currently is no explanation for this finding. For those who do not outgrow the disorder, medication should continue. Managing levels of medication should be a team effort between the physician and the child. Dosage levels need to be evaluated and adjusted depending on the environment and demands on the adolescent.

Behavior management can sometimes decrease the symptoms of attention deficit disorder but since this type of therapy requires high motivation and a high expenditure of attention and psychological energy, it does not help most adolescents.

Follow-up studies on the effectiveness of stimulant medication on the disorder have produced conflicting results. For example, one study found that the outcome ten to twelve years later was not significantly different than that of a matched control group. However, another study found a significant percentage of children with attention deficit disorder were later apprehended for major criminal activities. The authors believe these studies point to the need for many careful longitudinal investigations.

Comment: This article is somewhat limited in its discussion of treatments and does not explore other therapies to deal with secondary emotional problems of adolescents with attention deficit disorder.

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Simon, J.I. (1984). The borderline syndrome in adolescents. *Adolescence, 19*(75), 505-520.

Synopsis: This article is a description of diagnostic procedures and treatment options for adolescents with a borderline syndrome.

Borderline syndrome has historically been difficult to define and classify. Its existence is generally accepted, but there are still a wide range of personality characteristics associated with it that makes diagnosis difficult. Some shared characteristics are low self-esteem, extreme sensitivity to criticism and rejection, and fearfulness. Adolescents with borderline syndrome use denial and projection and their reality orientation is often deficient. The disorder appears related to developmental factors and a lack of personal identity.

Simon believes that an understanding of object relations theory helps in treatment planning for these adolescents. This theory is that a sense of identity is associated with relationships with external objects. Adolescents with borderline syndrome have not internalized object relationships so they lack the capacity to trust and therefore their ability to cope with stress related to establishing relationships. This phenomenon effects the ability to separate and any sense of identity is threatened.

The degree of severity of the disorder is very relevant to treatment planning as is the adolescent's capacity to trust. Therapy is often difficult on an out-patient basis because of the resistance of the adolescent and the lack of skill on the part of the therapist. Therapy is more effective in an inpatient facility with experience working with adolescents and with borderline disorders. These settings provide structure and protection and, most of all, time for the therapist to get through the distrust. Because hospitalization is costly, an alternative is a day treatment program. The program should provide structure and limitations. Day treatment programs should work with families to support the growth of the adolescent.

Drug therapy may be indicated for psychotic episodes and coexisting affective disorders. The author warns, however, "...while drugs may be essential, the problem of the borderline is basically a personality disorder, and psychotherapy and constructive growth experiences have the major role in treatment." Simon advocates intensive psychotherapy for several years, but only if the therapist is very skilled and available for the duration of the treatment.

Comment: This article has a psychoanalytic focus on how to achieve positive therapeutic gains with adolescents who exhibit borderline syndrome.

*Snyder, J.J. & White, M.J. (1979). The use of cognitive self-instruction in the treatment of behaviorally disturbed adolescents. *Behavior Therapy, 10*(2), 227-235.

Synopsis: This article is a description of a study of the outcomes of three interventions used with institutionalized adolescents with behavior disorders--cognitive self-instruction, contingency awareness, and assessment control.

The subjects for this study were nine male and six female adolescents in a residential treatment center because of severe behavior problems. These adolescents were selected because an operant behavior modification program used at the center had not improved their behaviors. These fifteen adolescents continued to use drugs, run from the program, skip school, and demonstrate frequent impulsive behaviors. The adolescents had been in this placement for an average of 7.7 months (range four to seventeen months).

The youth were randomly assigned to three groups: cognitive self-instruction, contingency awareness, or assessment control. The groups did not vary significantly on age, race, number of referral problems, type of placement, or level of placement prior to the study. They all continued to be involved in the operant behavior modification program. The cognitive self-instruction and contingency awareness groups met for six forty-five minute sessions in a four-week period with co-leaders. In the cognitive self-instruction group, the adolescents were asked to describe the difficulties they were encountering in the behavior modification program. They were presented with the concept of private speech and its effect on behavior. Using the personal experiences of group members, the adolescents role-played, modeled, and used social reinforcement to discover more adaptive self-verbalizations (including a statement of contingencies, the demands of the task, and self-reinforcement for success). The adolescents rehearsed the verbalizations and by the end of the sessions were applying the techniques in their day-to-day lives.

The contingency awareness group also focused on difficulties they were experiencing with the behavior modification program. The leaders made suggestions about behavior changes that would enhance chances for reinforcements in the center program. Contingencies were discussed and emphasized and group suggestions were encouraged. There was no modeling, role playing, or counterconditioning. The adolescents were encouraged to try some of the suggestions in their day-to-day lives and discuss successes and failures with the rest of the group.

The subjects' performances on target behaviors were measured before and after treatment and at a 6-week follow-up. The results indicate that the addition of cognitive self-instruction to the operant behavior modification program resulted in greater change in increased class attendance, decreased impulsivity, and increased completion of social/self care responsibilities. The authors maintain that the beneficial effects of self-instruction accumulated during the follow-up period which suggests that the adolescents were able to learn and use self-observational, self-instructional, and self-reinforcement skills.

Comment: This study is of interest because it shows how an additional component can make an existing intervention more effective. Caution is advised because of the small sample.

Stone, C. & Bernstein, L. (1980). Case management with borderline children: Theory and practice. *Clinical Social Work Journal*, *8*(3), 147-160.

Synopsis: This article is a description of a case management approach with a collaborative relationship between parents and teachers in working with children with borderline disorders.

This article begins with a description of the stages of development related to separation from the mother which, if fixated at any point, can result in borderline personality disorders. Most therapists who work with children with these disorders want to involve the parents in the therapy. Because these children are demanding and draining in any environment, it is also important to look to the school for support, guidance, and insight to cope with the child. Although each family is unique, the authors offer some general points about work with parents. First, there is "a good possibility that the parents of a borderline child have some degree of borderline pathology themselves that may surface in whatever kind of therapeutic contact they are offered." Secondly, therapists can appeal to the parent's intellectual understanding of the developmental tasks facing the child. This educational approach is accepting and nonjudgmental; with some parents, it is helpful to provide tasks or suggested ways of responding to the child. Thirdly, the authors feel it often works best to have the child's therapist also be the "one to work collaboratively with the parents on behalf of the child. If the parents need individual therapy, however, it is better that they find another therapist..."

The first step in working with teachers is to explain what borderline pathology involves in terms teachers can relate to and understand. This explanation is best given over time and in relation to described behaviors. Most children with borderline disorders need additional structure, and a therapist can help the teacher with strategies to provide this structure. For example, by discussing the child's behavior patterns, the therapist and teacher can devise ways to prepare the child for changes in routines. The teacher needs to be creative and flexible.

The authors conclude that, "... both parents and teachers experience some relief from the borderline child's perplexing pathology when they have some understanding of the meaning of his behavior. They can be encouraged to implement this understanding by developing supportive structures in the child's environment."

Comment: This article, which includes two case vignettes, is a description of environmental modification and collaborative approaches to working with parents and teachers of children with borderline disorders.

Strauss, J.S., Downey, T.W. & Ware, S. (1980). Treating children and adolescents in the same psychiatric inpatient setting. *American Journal of Orthopsychiatry*, 59(1), 165-68.

Synopsis: These authors propose a model of treating children and adolescents in the same psychiatric inpatient setting, a practice that is not widely implemented.

The practice of integrating age groups in psychiatric facilities has not occurred since the horror story days of children mixing with adults in mental hospitals. The authors feel there may be benefits to integrating adolescents and children in inpatient settings. In fact, ". . . a person's freedom to feel toward, talk with, help, and learn skills from individuals of various ages might be harnessed as an important component of treatment."

In developing such a program, several factors need to be considered. Because there are no data available regarding advantages and problems with such an approach, it may be wise to begin with an adolescent/child tutorial program with three components. The first would be a tutor-tutee relationship whereby the adolescent would give affection and help to a child. The second would be a supervisor-tutor relationship where a staff person would work with the adolescent in a collaborative way toward a common goals--helping a child. The third component would be supervised tutor-tutor group meetings, led by a supervisor, where experiences would be shared and peer relationships improved.

The authors feel it would be best to start with relatively well-functioning children and adolescents. If the model works well with these children and adolescents, children and adolescents who have a more severe disturbance could be included. It might be best to begin with a small number of interested staff who can work with mixed age groups.

Beside the therapeutic benefits, this model could provide a basis for research regarding developmental levels of psychopathology related to treatment interventions.

Comment: These authors propose a unique approach to inpatient treatment that has not been attempted previously. They propose a conservative phased approach to implementation.

Wahler, R.G. & Graves, M.G. (1983). Setting events in social networks: Ally or enemy in child behavior therapy. *Behavior Therapy, 14*(1), 19-36.

Synopsis: This article is a discussion of the production and maintenance of improvements in behavior related to environmental events.

The authors looked at treatment "failures" that were not child-centered but were environmental. They believe that "...the follow-up failure studies provide a cogent argument for broadening one's view of the troubled child's social network. In some families, it seems apparent that skill acquisition geared only to the child's problem behavior is not sufficient." The term "setting events" is used to describe environmental conditions that may be distant from the treated behavior. The authors describe a case in which a child's behavior improved after the mother was trained to use behavior management strategies. The improvement was not evident at follow-up. The suggestion is that the mother's relationship with her own invalid mother, which was stormy and guilt-ridden, was a setting event that contributed to the treatment failure. The mother's anger at her own mother interfered with her ability to follow through on the behavior modification plan for her child. The authors note, "In pathological interchanges between a child and other members of his or her natural groups, setting events may exert powerful stimulus control over these interchanges, although a clinical observer might judge the setting event as irrelevant."

The authors suggest ways in which therapists can elicit information from families. To supplement parent training programs, summary reports from the parents would include coercive encounters with people other than the child. These encounters could be discussed in relation to interactions with the child. The very act of asking a parent to report coercive interchanges not related to the child can tune the parent into a wider view of multiple coercions. The authors have used this expanded model and report a gradual decrease in the number of negative parent-child interactions mentioned in parental summary reports even though the parent continues to include other coercive encounters. The authors have concluded that the phenomena of setting events ought to be a focus in child behavior therapy.

Comment: The concept addressed in this article is the basis for an ecological model of intervention, and it is addressed from a clinical (rather than case management) point of view.

Treatment Strategies

*Wahler, R.G. & Fox, J.J. (1980). Solitary toy play and time out: A family treatment package for children with aggressive and oppositional behavior. *Journal of Applied Behavioral Analysis, 13*(1), 23-39.

Synopsis: This article is a description of interventions applied to children's oppositional, aggressive behaviors.

The purpose of the study described in this article was to "assess the therapeutic properties of solitary play in family-based treatment of children whose behavior is aggressive and oppositional." Four young children referred for psychological help were observed in thirty-minute segments in the home at times the parents reported their behavior was the most problematic. After it was determined what the problem behaviors were, a solitary play contract was negotiated with the child and parents. The child was asked to play alone for a designated time period in the presence of other family members. The child could not approach others or attract attention and had to ignore others if approached. If the child fulfilled the requirements for the designated time, stars were awarded leading to rewards. The initial time span was selected by the parents as one they felt the child could master. The time span was increased each day (along with point values) up to a maximum of thirty minutes. Points were cashed in at the end of five days of consecutively completed contracts. Parents were instructed to provide approval whenever they observed their children engaged in solitary play.

For all four children involved in this study it was eventually necessary to add a time-out component to suppress oppositional behavior. If household rules were broken or the child did not comply with parental instructions, quiet time in a designated room away from the family for five minutes was instituted. The time-out component was added because the desirable outcomes of the impact of toy play were transitory.

The authors conducted an elaborate and complex evaluation of this intervention. After analyzing the data, they concluded that toy play alone will reduce oppositional behavior, at least temporarily. In combination with time-out intervention, toy play is effective as a strategy to reduce aggression in children. The authors also argue that solitary play does not connote maladjustment or immaturity as some child development professionals have suggested.

Comment: The authors explore solitary play which is a rarely mentioned intervention for children who are oppositional and aggressive.

Webster, R.E. (1981). *A cognitive-behavioral approach for dealing with emotionally disturbed adolescents in a public school setting. Instructor's manual.* Manchester Community College, Manchester, Connecticut (ERIC Document Reproduction Service No. ED 213 166).

Synopsis: This instructor's manual is a description of using cognitive behavior modification with mainstreamed adolescents who have emotional disorders.

The manual is for a series of workshops to train teachers to use a cognitive behavioral management approach with students who exhibit non-compliant behaviors. Teachers collect baseline data on a targeted behavior to determine how often it occurs, when it occurs, and under what types of circumstances. Once the baseline is established, a reinforcement program can be developed. Data then are collected to determine the success of the intervention.

Traditional behavior modification programs generally have not been effective in non-residential settings. To develop a model for use in a public school setting, several factors need to be considered. Teachers must be sensitive to both environmental and student variables. They must establish a trusting relationship with students so there is some basis for developing a behavioral management strategy based on individual circumstances. In developing a cognitive-behavioral intervention plan with a student, the educator must clearly define target behavior; collect baseline data on the behaviors; develop a self-monitoring system with the student (if possible); compare and discuss the student's self-monitoring data with that collected by the teacher; set mutually agreed upon goals toward reducing the incidences of the behavior; teach new ways of behaving through analyzing the situation and interpersonal feelings, brainstorm new ways to behave, and practice those behaviors; and analyze the success of the alternative behaviors.

The author makes it clear that the process is not a simple one. The intervention requires frequent and positive feedback done on an individual basis perhaps with graphic displays or increased responsibilities for the adolescent.

A case example is presented that describes the steps of implementation.

Comment: This is a training manual in that it includes trainee exercises and activities. The paper is interesting in that it is a description of a structured behavior modification intervention in a regular public education setting.

*Webster-Stratton, C. (1984). Randomized trial of two parent-training programs for families with conduct-disordered children. *Journal of Consulting and Psychology, 52*(4), 666-678.

Synopsis: This article is a description of a study involving training for mothers of children with conduct disorders.

The author feels that there is a need to improve the cost efficiency of training programs for parents of children with conduct disorders because individualized programs are costly, time consuming, and incapable of meeting increasing demands. The purposes of this study were 1) to evaluate the short and long term effectiveness of a standardized, therapist-led, videotape modeling, group discussion program in altering parent attitudes and parent-child interactions in a clinical population, and 2) to compare the effectiveness and cost efficiency of this program with the more widely utilized individualized therapy involving feedback, rehearsal, and live modeling.

The study involved thirty-five families randomly assigned to either of the two treatment models or to a waiting control group. The baseline assessment consisted of two home observations, twice weekly telephone reports of child behaviors, and questionnaires. The two training groups each received nine sessions that included a modification of the interactional model and teaching a specific set of operant techniques. The process differed between the two groups. In the therapist-led group discussion program, eight to ten parents viewed 180 videotaped vignettes of parents and child engaged in both desirable and problematic interactions. The therapist then led a discussion of the skills used and elicited the parents' responses. Children were not present, and parents did not rehearse the skills. The second training model involved one-to-one sessions between the therapist, parent, and target child. The therapist modeled the parent-training skills while the parents role-played and rehearsed the skills with their child. The therapist provided direct feedback.

Both treatment groups were compared with the waiting list control group and with each other. Both parental behavior and child behavior variables improved for the treatment groups. In analysis of the results between the two treatment groups, there were no significant differences on any of the mother or child variables except for the mother direct command ratio which was significantly lower for the videotape modeling treatment group. At follow-up one year after treatment, "the significant mother behavioral improvements reported immediately post-treatment were maintained one year later. However, child noncompliance and deviancy behaviors, which had shown only borderline decreases immediately posttreatment, continued to show decreases one year later."

Since the principal purpose of this study was to develop a more cost-effective and widely applicable program for parents, the author concludes, "...videotape modeling, therapist-led small group discussion is effective with a wide variety of parents of conduct-disordered children."

Comment: This study included a rigorous research component that adds validity to the efficacy of the videotape-training model.

*Webster-Stratton, C. (1985). Predictors of treatment outcome in parent training for conduct disordered children. *Behavior Therapy*, *16*(2), 223-243.

Synopsis: This article describes a study to assess a nine-week behaviorally oriented parent training program for parents of children with conduct disorders.

Reviews of the literature on parent training programs indicate that they may work for some families but not for others. The author suggests that success or failure of parent training could be related to variables such as the parents' cognitive, psychological, and marital adjustment and to socioeconomic status. She states, "The purpose of this study was to define predictor variables which are related to treatment success or failure for families of conduct disordered children. Moreover, treatment outcome success or failure was determined in terms of parent behavior and attitude change as well as child behavior change."

Parents were recruited from a psychiatric and behavioral clinic. The criteria for selection were: 1) the child was between three and eight years old; 2) the child had no debilitating physical impairment, intellectual deficit or history of psychosis; 3) the primary referral problem was conduct disorders; and 4) parents agreed to home visits and filling out questionnaires. Thirty-four families participated in the study. Prior to treatment, all mothers were interviewed to provide information on: 1) family income; 2) maternal education; 3) family composition; and 4) source of referral. Parents also were tested on depression, life experiences, and perceptions of child behaviors. A home visit elicited information on parent-child interactions.

The training consisted of a series of nine two-hour weekly sessions that included four weeks focusing on positive interactional and play skills and five weeks on teaching a specific set of operant techniques (praise, ignoring, giving commands, and time out). Treatment outcome was assessed at one month and at one year post-treatment.

Families were classified as "responders" or nonresponders" to treatment on the basis of four criteria: 1) child behavior; 2) parent perceptions of child behaviors; 3) parent behaviors; and 4) a combination of parent and child behaviors. The major results showed that over half the families were helped by the parent training, and the attitude and behavior changes were maintained or improved one year after treatment. Data from one-year follow-up are more predictive of success or failure. Findings indicated that: 1) the more disadvantaged the family, the less likely they were to benefit from training; 2) lack of social support was a predictor of nonresponse; 3) a high negative life experience score was more associated with nonresponders on the criterion of mother attitude; and 4) the pretreatment depression measure was not a good predictor of treatment success or failure. In summary, single parent families with economic difficulties and lack of support were significant predictors of nonresponse to treatment. These findings suggest that mental health professionals need to alter treatment programs (and parent training concepts) to include help with socioeconomic difficulties and negative life and social supports.

Comment: This article is a discussion of a relatively complex research methodology that has the potential to contribute to strategies of working with families more effectively.

Welch, V.O. & Sigman, M. (1980). Group psychotherapy with mildly retarded, emotionally disturbed adolescents. *Journal of Clinical Child Psychology*, 9(3), 209-212.

Synopsis: The authors maintain that group psychotherapy is a powerful tool in aiding the adjustment of adolescents who have mental retardation and emotional disorders.

Traditionally group therapy has not been used with the mentally retarded for various reasons. First, the degree of emotional problems of this population has been underestimated. Secondly, the treatability is not recognized often because of a misconception that behavioral and emotional problems are a function of retardation and not of interpersonal relationships. Third, emotional disorders in children who have mental retardation are often seen as different from those with normal intellect.

The authors feel that significant gains can be made with a group psychotherapy treatment approach with adolescents who have emotional disorders and mild to moderate retardation. This article addresses the benefits and difficulties of this approach with groups of six to eight adolescents, aged twelve to eighteen. Criteria for selection to a group is the ability to communicate verbally and an interest in being a member. The therapeutic goal is for the adolescents to become more skilled socially and become more aware of and better able to express their feelings.

The treatment problems unique to this population include: 1) the discrepancy between chronological age and mental age; 2) multilevel problems of a great variety including physical problems; 3) the need for the therapist to be a very active leader and very concrete and explicit; and 4) the need to use nonverbal techniques such as play, games, role play, music, and drawings.

Despite these special considerations, there are advantages to group treatment for this population, including: 1) a sense of belonging; 2) decreased feelings of anxiety and inadequacy; 3) provision of behavior models; 4) opportunity for feedback; and 5) increased verbal skills. The authors have not formally assessed outcome for group members but offer some subjective impressions. There has been increased social awareness and decreased egocentricity and narcissism. Group members express more statements indicating concern for others and more expressiveness. In concluding, the authors state, "...we would advocate group treatment for outpatients as well [as inpatients]. A group treatment approach can make a unique contribution to the treatment of retarded adolescents because of the advantages associated with peer interaction, modeling, and the greater ability to concretize concepts and increase verbal exchange within a group process."

Comment: This article makes a unique contribution for those who are involved with adolescents with a dual-diagnosis of mental retardation and emotional disability.

Treatment Strategies

Wilson, M. R. (1983). The adolescent psychiatric patient with processing deficiencies: Some personality characteristics and treatment strategies. *Adolescence*, *28*(71), 479-488.

Synopsis: This article is a discussion of the relationship between perceptual processing and psychiatric conditions. In adolescents this combination results in unusual personality characteristics that require special treatment strategies.

The author describes a syndrome composed of perceptual processing deficiencies and various conditions including learning disabilities, hyperkinesis, enuresis, encopresis, attention deficit disorder, and psychosis. Perceptual processing is one of the five stages of auditory or visual perception that can be divided into three activities: 1) affective and cognitive charge that gives meaning, feeling, and value to that which is perceived; 2) continuity which associates a perception with its other sensory characteristics and with all past experiences with the stimulus; and 3) rate of perception. A newborn does not have the ability to process perceptions; this capacity is acquired as each of the senses matures. The cause of deficient perceptual processing is unknown but involves inadequate or flawed maturation of a particular perception. The author states, "The sequential maturation of and capacity to process vision, and then hearing, are critical stages in the separation/individuation process." Lack of maturation results in compromised ego development.

Adolescents with symptoms of psychosis and with other disabling emotional problems display personality characteristics associated with deficiencies in perceptual processing, especially related to discontinuity. These adolescents lack the ability to conceptualize, make choices, anticipate, discriminate, or to fit parts into the whole.

The traditional treatment for perception processing deficiencies is tutoring for specific learning disorders and medication for attention deficit disorders. Wilson has developed some additional treatment strategies. One involves having the adolescent free associate followed by a summary by the therapist and then a discussion of the material. For those with auditory process deficiency, this enhances the effectiveness and meaning of psychotherapy. Another strategy, designed to enhance continuity, involves daily psychotherapy, daily tutoring, daily academic classes, each at the same time every day. Sensory compensation helps overcome a lack of self confidence. Skill development of senses without processing deficiencies provides areas of success and sources of satisfaction. A high stimulus level can compound discontinuity. To reduce this level in an institutional setting, room changes, noise levels, staff changes, and schedule changes should be minimized.

Comment: This article is very technical when discussing the origin and dynamics of perceptual processing. However, the treatment strategies are simple but innovative. Some involve environmental modifications.

Young, H.S. (1983). Principles of assessment and methods of treatment with adolescents. In A. Ellis & M.E. Bernard (Eds.) *Rational-emotive approaches to the problems of childhood* (pp 89-107). NY: Plenum Press.

Synopsis: This chapter is a description of the use of rational-emotive therapy (RET) with adolescents. It includes a condensed interview.

This author refreshingly defines self-defeating adolescent behavior as a "result of the young person's evaluation and appraisal of his or her life experiences rather than being the result of any particular set of biological, social, or environmental circumstances." He continues, "Adolescents seem to find it incredibly easy to turn disappointments into disasters; desires into demands; wants into necessities; difficulties into impossibilities, and failure and criticism into proof that they are subhuman creatures." Young feels the most effective approach with adolescents is rational-emotive psychotherapy that is structured along four dimensions: relationship building, problem defining, problem intervention, and problem solving.

Disclosure of private thoughts, fantasies, and feelings is essential to cognitive analysis and intervention. Adolescents are not accustomed to discussing these concerns with an adult. Some approaches Young has found helpful are: 1) allowing long periods of uninterrupted listening; 2) accepting the adolescent's reality perspective regardless of how distorted or limited it may be; 3) the therapist discussing openly his or her own opinions and attitudes; 4) allowing a companion to sit in on a session; 5) giving the adolescent priority; and 6) extracting some concession from the parents.

Defining the problem is another essential element of RET. Some tactics to encourage adolescents to focus on a problem are: 1) defining the problem for the adolescent; 2) simplifying the definition of a problem; 3) using a representative example from the life of another young person; 4) the therapist offering a problem example from her or his own life; 5) using visual aids (posters); and 6) unraveling the problem from a rambling dialogue.

Problem intervention in RET involves "helping clients learn to recognize, challenge, and correct irrational attitudes that cause emotional distress and generate self-defeating behavior." Some suggestions of how to impart rational insights with adolescents are: 1) teaching (or not teaching) the relationship between thinking, feelings, and actions; 2) confronting and disproving "awfuls," terribles," and "horribles"; 3) confronting and confuting "shoulds," "oughts," and "musts;" 4) challenging the "can't stand" philosophy; 5) teaching the principle of self-acceptance; and 6) correcting misperceptions of reality.

Problem solving in RET "is usually accomplished by persuading clients to put the knowledge gained in therapy into practice in concrete and specific life situations." Some helpful tactics are: 1) explaining psychological and emotional problems as habits; 2) checking out the client's expectations about therapy; 3) sticking to accepted insights; 4) telling the adolescent what to think; and 5) arranging homework assignments.

Comment: This article is full of practical and clear examples of how to work with adolescents.

Young, T.M. (1988). The development and disturbance of emotions: An application of self psychology to clinical work with children. *Child and Adolescent Social Work Journal*, *5*(4), 245-268.

Synopsis: This article is a description of the treatment implications of self psychology, as developed by Heinz Kohut, for clinical work with children.

Heinz Kohut developed the concept of self psychology as an alternative to the id, ego, superego model of Freud. Kohut's model is bipolar with one pole governing ambitions and the other ideals. A person's ambitions and ideals are connected whereby "...skills are developed from basic talent that, in turn, make possible the further expression of ambitions and pursuit of ideals." One's environment can facilitate the pursuit of ideals through the development of talents into skills which brings about cohesive development of self. The environment's failure to facilitate this development can lead to psychological suffering.

Clients in therapeutic relationships look to the therapist as an extension of themselves and try to use the relationship to gain responses that their environment has failed to provide. Kohut called this a "selfobject" relationship, whereby another person fills in to provide essential psychological functions. Eventually people can provide these functions for themselves most of the time. There are three major types of selfobject relationships: 1) mirroring which involves a joyful reflection of ambitions; 2) idealizing or merging with others to share their idealized strength; and 3) twinship which provides a sense of basic sameness and belonging. Failures in these relationships can lead to feelings of fragmentation, helplessness, and estrangement.

The use of a self-psychology perspective in treatment "influences how the therapist uses himself as a selfobject and it guides the therapist's understanding of and intervention in the child's selfobject milieu." The therapist must understand the inner meaning of play for the child in terms of a selfobject function the child wants the therapist to supply; the therapist should then provide this function. Therapists also should assess the adequacy of the child's selfobject environment and if it is inadequate, do something about it. As Young states, "For the child therapist, this implies a role of consultant/educator vis-a-vis the parents or other potential selfobjects." Once the therapist discovers ways of understanding the child's goals, ideals, talents, and skills, these can be conveyed to others in the child's milieu -- parents, teachers, neighbors, or babysitters. Young feels that although more work needs to be done in the use of self psychology strategies with children, "...it does hold some promise for rendering ecological approaches to child mental health more practical."

Comment: Although this article is complex and academic, it presents an exciting approach to working with children with serious emotional problems. The article includes three case illustrations that are helpful to understanding the concepts.

EVALUATION

Evaluation

*Arbuthnot, J. & Gordon, D.A. (1986). Behavioral and cognitive effects of a moral reasoning development intervention for high-risk behavior-disordered adolescents. *Journal of Counseling and Clinical Psychology, 54*(2), 208-216.

Synopsis: This article is a description of an evaluation of a moral reasoning development intervention used with aggressive and disruptive adolescents.

The study discussed in this article was conducted to assess the behavioral and cognitive effects of a sociomoral reasoning development program for high-risk adolescents with behavior disorders. The participants in the study were thirty-five male and thirteen female adolescents (thirteen years to seventeen years old) from four school systems in a rural county. All were identified by teachers as "behavior disordered" because of unruliness, aggressiveness, impulsivity, and disruptiveness; the students also were identified as "high risk" for delinquency because of stealing, lying, vandalism, and fire-setting. The forty-eight students were randomly assigned to either a control or treatment group.

Students in the treatment group at each school attended moral dilemma discussion groups for one class period a week for sixteen to twenty weeks. The first two sessions were spent building rapport. The students were interviewed the third week and again during the final session. The other sessions consisted of guided moral dilemma discussions and role-play. Two sessions dealt with listening and communication skills. The dilemmas involved using problem-solving and decision-making skills as well as focusing on rights, perspectives, and obligations of others. Moral norms covered in the discussions were life, property, truth, affiliation, authority, law, contract, civil rights, conscience, and punishment.

Results of analysis of data pre- and post-intervention (interviews with students, teacher ratings, referrals to school office for behavior problems, absenteeism and tardiness rates, grade point averages, and court or police contacts) indicated that in most areas those in the treatment group performed better than those in the control group. The treatment group scored significantly higher on sociomoral reasoning, had a much lower number of office referrals, had fewer tardinesses, had higher grade point averages in humanities and social sciences, and had ten times fewer court and police contacts. The areas of no significant differences between the two groups were teacher evaluations of behavior, absenteeism rates, and grade point averages in math, science, and nonacademic subjects. At a twelve-month follow up of a subsample from two of the schools the positive results of the treatment group remained.

The authors feel that, although more research is needed, "It appears from the present data that behaviors can be successfully modified by effecting changes in the structural basis of behavioral decisions."

Comment: This article contains some nice detail on the types of dilemmas discussed and the techniques used by discussion group leaders.

Evaluation

*Bloom, R. B. & Hopewell, L.R. (1982). Psychiatric hospitalization of adolescents and successful mainstream reentry. *Exceptional Children*, *48*(4), 352-357.

Synopsis: This article is a report on a six-month follow-up of eighty-eight adolescent patients of a state mental hospital.

The study described here looked at the mainstream reentry of hospitalized adolescents by examining the reinstitutionalization rates of a diagnostically heterogeneous group and analyzing selected clinical and demographic variables. The subjects of the study were eighty-eight adolescents discharged from a state mental hospital in Virginia during a thirty-one month period. Those discharged to another institutional setting (hospital, residential placement, or corrections) were not included. The eighty-eight adolescents included forty-eight males, thirty-six African Americans, and had a mean age of sixteen at admission. They had a variety of diagnostic labels including transient situational disorders (n=39), behavioral disorders (n=21), personality disorders (n=8), neurosis (n=3), organic brain syndrome (n=4), and psychosis (n=13).

The authors had available all of the adolescent's medical, psychological, social, and educational records. Variables analyzed included demographic data, diagnosis, commitment status, length of stay, previous hospitalizations, family information, discharge data, educational data, and reinstitutionalization information.

Of the eighty-eight adolescents, thirty-eight (43 percent) were reinstitutionalized within the six-month follow-up period. Five variables were significant in discriminating between the recidivists and nonrecidivists: 1) educational/vocational placement; 2) length of hospitalization; 3) family structure; 4) hospitalization of family member(s); and 5) type of discharge. More nonrecidivists were enrolled in public education, were from homes with at least one natural parent, had fewer family members hospitalized, had a shorter hospital stay, and were given "regular" discharges (as opposed to leaving against medical advice). The severity of the diagnosed problem did not account for variance in discriminating between the two groups. The most significant difference was the type of educational or vocational placement. "Adolescents placed in public school programs are the most likely to be successfully reintegrated into their communities." The second most powerful variable to success was living with at least one biological parent.

The authors suggest that even though treatment variables were not analyzed, it is doubtful they played a part as the program was essentially the same for all adolescents. The hospital program included an educational unit, a token economy milieu, psychotherapy and ward meeting groups, and little or no individual psychotherapy or family therapy. The authors state that this study supports the need for case managers, mutual planning, and high quality educational placements. In addition, "...this study strongly suggests that families must receive the support services necessary to maintain their structural integrity and the mental health of their members if chronic 'revolving door' patienthood for adolescents and adults alike is to be avoided."

Comment: This article is of interest because of its focus on the need for discharge or transition planning.

*Brown, R. T., Wynne, M.E. & Medenis, R. (1985). Methylphenidate and cognitive therapy: A comparison of treatment approaches with hyperactive boys. *Journal of Abnormal Child Psychology, 13*(1), 69-87.

Synopsis: This article is a description of a study of the effects of three types of treatment with boys who are hyperactive--cognitive training, drug therapy, and a combination of both.

The controversy regarding the most effective treatment strategy for children who are hyperactive continues despite many recent studies on the issue. Most of these studies report improvements in behavior and attention using drugs and/or behavioral models, but many studies show little improvement in academic performance and are methodologically flawed. The study reported in this article was undertaken to compare the effects of a program of cognitive behavior training, methylphenidate, and the combined effects of both with school-age boys with hyperactivity and academic problems.

Thirty boys who had serious and persistent symptoms of attention deficit disorder with hyperactivity, and no gross neurological, sensory, or motor impairment or psychosis, were randomly assigned to one of three treatment groups. These were 1) methylphenidate therapy, 2) cognitive training, and 3) methylphenidate combined with cognitive training. The age range was six to eleven years (mean=11.36). The training program consisted of twice-weekly one-hour sessions or twenty-four sessions over a three-month period. The goal was to teach the child to cope with cognitive problems and evaluate his own performance. Techniques included modeling, self-verbalization, structured routines of problem-solving, and breaking tasks into component parts. The children who participated in the methylphenidate therapy component received medication in the morning and at lunch. There was a no treatment control group of ten boys who were on a clinic waiting list.

The efficacy of each of the four treatment conditions was assessed by tests administered prior to training, immediately after training, and three months after training ended. The analysis of the results indicates that, "...although cognitive therapy alone resulted in improvement in measures of attentional deployment, the overall changes were not as large as in those treatment conditions employing medication." Academic improvement was not evident in any of the groups. The authors feel that medication is an effective treatment for these children; research is needed to determine if it increases the potential effectiveness of various psychological interventions.

Comment: The authors defend the use of stimulant medication for children with hyperactivity as a result of a methodologically rigorous research effort.

Evaluation

*Bush, R.M., Glenwick, D.S. & Stephens, M.P. (1986). Predictors of psychotherapy outcome for children at a community mental health center. *Journal of Clinical Psychology*, *42*(6), 873-877.

Synopsis: This article is a description of a study of outcome predictors for children and their families who received psychotherapy at a community mental health center.

This study was an attempt to discover the client, therapist, and fee payment variables that contribute to the outcome of outpatient child psychotherapy. The clients included in the study were 268 children who received and completed therapy at a semi-rural midwestern community mental health center during a four-year period. The mean age was 11.1 years, 92.2 percent white, 64.9 percent male, and 2/3 had had no previous psychological treatment. Information was collected from closed case files and included age, sex, socioeconomic status, household size, family constellation, referral source, distance to the center, previous treatment, and problem severity. Therapist variables included type (intern or permanent) and years of experience. Outcome was determined from global ratings of success for the child and family made by two advanced clinical psychology graduate students after reading the therapist's termination notes as well as by therapy attendance.

Children who had received previous treatment elsewhere stayed in therapy longer and had higher improvement ratings; so did those seen by permanent (rather than intern) staff. Clients with remarried parents had lower improvement ratings. Single-parent families had higher improvement ratings as did families seen by permanent staff. However, families (rather than individual children) seen by therapists with more years of experience received lower improvement ratings. This may be attributed to professional burnout or the assignment of "easier" cases to interns. Families referred by school systems received lower improvement ratings than those referred by other sources.

The findings of this study are open to some interpretation. For example, greater length of therapy by permanent staff may be attributed to various factors including skill in prolonging a therapeutic relationship and the pressure interns face to close a case rather than transfer it at the end of an internship. Although there was some overlap, there were differences in predictors for child and family outcome which suggests that therapists should consider family structure in planning.

Comment: This article is of interest because it describes therapist rather than client variables in relation to treatment outcome.

*Dolly, J.P. & Page, D.P. (1981). The effects of a program of behavior modification and reality therapy on the behavior of emotionally disturbed institutionalized adolescents. *The Exceptional Child*, *28*(3), 191-99.

Synopsis: This article is a report on a study that used behavior modification and reality therapy with adolescents who had severe retardation and emotional disabilities.

This study took place in an institution for people who have mental retardation. Twenty adolescents who had severe retardation and displayed the most serious maladaptive behaviors were selected for the study. They were placed in a separate residence and received intensive treatment over a two-year period. Staff were males and females in their late teens and early twenties, none college educated, who were trained in the use of reality therapy and behavior modification techniques.

A control group was selected from adolescents in the same institution who exhibited problems similar to those in the experimental group. However, members of the control group had higher scores on pretest measures of adaptive behavior. This group participated in the regular programs of the institution but received no special treatment.

Two instruments were used to measure the degree of adaptive and maladaptive behavior -- the AAMD Adaptive Behavior Scale and the TMR Performance Profile. The experimental group had significant increases in adaptive behaviors and decreases in maladaptive behaviors pre-post test.

The authors point out that from the data it was difficult to pinpoint which components of treatment were responsible for improved behavior. Through observation, it was determined that the most important improvement was the clients' ability to function without twenty-four-hour day care and supervision.

Comment: The authors report on a controlled study with an experimental design but do not describe the treatment interventions.

*Hersher, L. (1985). The effectiveness of behavior modification on hyperkinesis. *Child Psychiatry and Human Development*, *16*(2), 87-96.

Synopsis: This article is a review of studies of the effectiveness of behavior modification on hyperkinesis.

Hyperkinetic behavior includes hyperactivity, impulsivity, and inattention. Behavior modification therapy is a combination of ignoring undesirable behavior and rewarding positive behavior. Rewards can be given either immediately after the occurrence of a desired behavior or delayed, such as at the end of a school day.

Hersher examined all controlled studies published in the last twenty years of behavior modification used with children who exhibit hyperkinetic behaviors. All could be identified as utilizing either immediate or delayed reward. Analysis of the studies revealed that children who have highly kinetic behaviors (those described as "hyperactive" in DSMII) are less likely than moderately active children to respond to behavior therapy techniques regardless of the timing of the reward. The children who have highly kinetic behaviors did change somewhat when a reward was given immediately following a decrease in activity.

Only one study followed the children for more than one month after termination of treatment. This study revealed that the children who received behavior modification were no less impulsive or hyperactive than a control group of children whose parents received Parent Effectiveness Training.

Few studies have been conducted on the adverse effects of behavior modification. One study using immediate rewards did find an increase in the aggressive behavior that the therapy was intended to decrease. Successful methods are extremely time-consuming for the therapist and/or parent which may lead to increased overactive and disruptive behavior from other children in the home or school.

Comment: This article, a comprehensive look at studies of the effectiveness of behavior modification therapies with children, would be of interest to those in the academic community and program evaluators.

Evaluation

*Higgins, J.P. & Thies, A.P. (1981). Problem solving and social position among emotionally disturbed boys. *American Journal of Orthopsychiatry*, *51*(2), 356-358.

Synopsis: This article is a description of a small study to determine the relationship between problem solving skills and social status with peers among boys who have emotional disorders.

The subjects of this study were thirty-eight boys, aged eight to thirteen, in a residential treatment facility for serious learning and behavior problems. The facility had five living units. Each child was given a sociometric questionnaire that asked him to list the three boys from his unit who he would most like to have accompany him on a trip. He was then asked to list the three he would least desire to have with him. The four most popular and four least popular boys from each unit were selected for this study. Two were excluded because of early discharge. The boys were given a test consisting of six stories portraying problem situations (the Means-End Problem Solving Test). There were no differences between the high and low popularity groups in IQ scores.

The results of the analysis of the Means-End scores revealed a highly significant relationship between popularity and problem-solving ability. The more popular children saw a broader spectrum and greater number of possibilities for reaching goals.

Higgins and Thies maintain that problem-solving training has improved impulse control, self-esteem, and feelings of competence among adult psychiatric patients. They feel that, "With the severe deficiency in means-end thinking exhibited by the children in this sample, a logical next step is to test the therapeutic effects of similar training on a group of behaviorally disturbed children."

Comment: The authors advocate the use of previously demonstrated problem-solving training techniques for adults with children who have emotional problems.

Evaluation

*Hobbs, S.A., Moguin, L.E., Tyroler, M. & Lahey, B.B. (1980). Cognitive behavior therapy with children: Has clinical utility been demonstrated? *Psychological Bulletin, 87*(1), 147-165.

Synopsis: This article is an exploration of the studies conducted to determine the efficacy of cognitive behavior therapy with children.

In cognitive-behavioral treatment, the child "is taught to employ mediating responses that exemplify a general strategy for controlling behavior under various circumstances." There are three general types of training used to elicit cognitive responses: 1) problem-solving techniques; 2) self instruction; and 3) cognitive modeling. The purpose of this article is to "review the literature and draw conclusions regarding the clinical utility of the cognitive-behavioral approach with children." The major areas examined are: 1) impulsivity; 2) hyperactive and aggressive behavior; 3) academic and classroom behavior; and 4) delay of gratification and resistance to temptation.

The authors review the numerous evaluations of cognitive-behavioral trainings in each of these four areas. In many studies, the interventions have been associated with positive changes in child functioning. However, to determine the clinical utility of cognitive-behavioral training, it is necessary to examine the subjects, treatments, target behaviors, dependent measures, and experimental and statistical methodology involved in the investigations. The authors of this article discovered some interesting factors. "Investigations that have evaluated the therapeutic utility of cognitive behavior therapy techniques with clinical populations of children constitute a minority of the studies reported and are generally confined to a relatively narrow range of problems." Descriptions of treatment often do not provide enough information for replications. The studies involving clinical treatment often do not focus on behaviors in home or school environments but rather on performance on psychometric instruments. A minority of the studies present follow-up data, and those that do generally restrict post-treatment report periods to one to two months.

Comment: This article includes an extensive review of the studies done on the efficacy of cognitive-behavioral therapy with children.

*LaBarbera, J. (1984). Overcontrolled children and outcome of short-term psychiatric hospitalization. *Child Psychiatry and Human Development, 15*(1), 21-33.

Synopsis: This article is a discussion of the results of a study of the psychological changes exhibited by children after a three-month psychiatric hospitalization.

This study was a beginning attempt to assess the therapeutic effectiveness of psychiatric hospitalization of children that lasts no longer than ninety days. The study was designed to measure behavioral changes. A secondary purpose was to look at the mother-child relationship and its association to these changes. The hypotheses were that maternal undercontrol is tied to aggression and misbehavior and overcontrol is tied to withdrawal and social inhibition.

The subjects of the study were twenty-six children admitted over an eighteen-month period to a short-term program in the Division of Child Psychiatry at Vanderbilt University Medical Center. Twenty children were male, six were female; the mean age was 9.92 years (range from eight to twelve); the mean IQ was 93.75; average length of stay was eighty-six days; and the families represented a broad range of socioeconomic backgrounds. Excluded from this study were children who had mental retardation, had organic brain syndromes or autism, those accepted on an emergency basis, and children whose parents were not involved in the treatment.

The residential program has a sixteen-bed capacity, admits patients for a maximum of 120 days, includes a school, recreational therapy program, occupational therapy program, individual therapy, parent counseling, psychological testing, milieu therapy, and views parental involvement as pivotal in the child's treatment.

The researchers used the Devereaux Child Behavior (DCB) rating scale to assess behavioral changes. Two independent nurses with direct patient contact assessed the behavior fourteen days after admission and seven days before discharge.

The results of the study indicate that hospital treatment did not significantly reduce any specific behavior disturbances for subjects as a group. This is disturbing considering the disruptive effect associated with this type of intervention: family relationships, removal from school system, financial hardship, parental guilt and labeling. However, the findings also indicated that although therapeutic change did not occur for children in general, certain categories of disturbances were amenable to short-term inpatient hospitalization. Children whose mothers were rated overcontrolling improved in the areas of emotional detachment and social isolation. This limited finding supports the philosophy that it is not useful to ask if a certain therapy works; rather the question is, Who does it work for and under what conditions?

Comment: This article is refreshing in that it is one of few that admits that an intervention is not particularly effective.

Evaluation

*Lewis, W.W. (1984). Ecological change: A necessary condition for residential treatment. *Child Care Quarterly, 13*(1), 21-29.

Synopsis: This article is a report on a study that followed-up on two groups of children who had been in residential treatment--a group that had improved the most and one that had improved the least.

The importance of ecological planning or management has gained recognition as an integral component of treatment for children and adolescents leaving residential treatment. The author states, "Basically, the idea is that any child who is identified as emotionally disturbed or behaviorally disordered has had a history of negative transactions with members of his ecology--parents, teachers, peers, etc.--that have resulted from a lack of congruence between ecological demands on the child and his ability or willingness to respond to those demands." A treatment program that includes ecological planning tries to do two things: 1) increase the child's ability to respond more appropriately to ecological demands; and 2) increase the skills and resources of other ecological participants in facilitating the child's development. The goal is a better fit between a child's skills and the demands and responsibilities of the environment.

The study described here was designed to determine influences on later adjustment of ecological changes that occurred as a part of the child's treatment. The researchers were interested in the interaction between success following treatment and the treatment process itself as seen in written treatment plans. Two groups of eighteen were selected for study--the 20 percent who were rated most improved and the 20 percent rated least improved, selected from a population of eighty-nine consecutive admissions to a residential treatment program for adolescents who had moderate to severe disabilities.

There were no significant differences in age, IQ, length of stay, or race between the groups on admission or at discharge. Children in both groups were successful in meeting their behavioral treatment objectives while at the facility. All adolescents in the program had specific behavior change objectives and ecological change objectives. The latter included elements such as increasing parents' management skills, arranging a special school program, or increasing support from community agencies. The results of the study indicate that six weeks after discharge, the most improved group met over 80 percent of their ecological objectives while most of the low group met less than 20 percent of theirs. All but one in the high improvement group were living in community settings--their own homes, group homes, or foster homes. In the low improvement group, almost half were in corrections or mental health institutions.

This difference between the two groups just six weeks after discharge is striking. The author states, "The only major difference that appeared during treatment was that significantly more of the ecological objectives were met for the high improvement group." Also, the author says, "Improvement in student's personal behavior obviously is important, but for that change to be sustained following treatment there must be concomitant improvement in ecological support." Why this change occurs in some support systems and not in others needs further study.

Comment: This article is very relevant as a support to the Therapeutic Case Advocacy philosophy of environmental modification.

Evaluation

*Lochman, J.E. (1985). Effects of different treatment lengths in cognitive behavioral interventions with aggressive boys. *Psychiatry and Human Development 16*(1), 45-56.

Synopsis: This article is a report of a study of the effects of length of cognitive behavioral treatment on boys who are aggressive.

Initial indications are that cognitive behavioral interventions with children who are aggressive are promising but that not all dependent measures contribute to positive short-term outcomes. Little research has been conducted to determine which aspects of the treatment affect outcome. No research has examined length of treatment in relation to outcome. The study reported here looked at the relative effectiveness of an eighteen session cognitive behavioral intervention for boys who are aggressive. The changes in on-task and off-task classroom behaviors were contrasted to changes previously reported in the behavior of four cells of subjects subgroups examined during the previous year. The results of this prior study indicated that a twelve session cognitive behavioral-plus-goal-setting intervention and the twelve session cognitive behavioral-only intervention produced greater reductions in disruptive and aggressive off-task classroom behavior than the minimal treatment intervention group or the untreated control group. The cognitive behavioral-plus-goal-setting group produced the strongest effects.

The current study included twenty-two males with an average age of ten years, four months. They were selected by teachers as the most aggressive and disruptive boys in their classrooms. The Anger Coping Plus Goal Setting (ACGS-18) treatment groups were co-led by a school counselor and by psychology and social work trainees. The groups consisted of five to six boys and met for forty-five to sixty minutes for eighteen sessions. Raters observed each subject's classroom behavior before and after the intervention.

The longer treatment produced greater improvement in on-task classroom behavior and reductions in passive off-task classroom behavior than did the shorter session version of the same intervention. However, both treatment lengths were equally effective in reducing disruptive-aggressive off-task classroom behavior. The authors feel that the results of this study point out the need for further research on components of types of interventions as well as therapist roles and generalizability across time and settings.

Comment: This article is a description of a program that was limited in scope and had little description of the treatment interventions.

Evaluation

*Masten, A.S. (1979). Family therapy as a treatment for children: A critical review of outcome research. *Family Process*, *18*(3), 323-335.

Synopsis: This article is a review of outcome research on the value of family therapy as a treatment for child psychopathology.

The author selected studies to review based on three basic criteria: 1) the child is the "identified" patient; 2) at least one parent and the child were seen conjointly in therapy; and 3) the child's behavior was evaluated after treatment. Fourteen studies were found that met these criteria. Few of the studies were well-controlled which led to difficulties in making comparative judgments.

The more methodologically sound studies suggested that for "soft" delinquency, short-term family therapy led to reduced recidivism. Also, family therapy had better results than individual therapy for short-term treatment of hospitalized adolescents where rehospitalization rates were used as an outcome measure.

Masten feels that "...it would be premature for a family therapist or a defender of child-centered therapy or any other advocate to debate the value of family therapy compared with other forms of treatment for children. The data base is too thin to substantiate the claim that conjoint family therapy is the treatment of choice for children or even any particular subgroup, but there is no strong evidence to the contrary either."

The author suggests a number of points to consider in the design of future research efforts. She emphasized: 1) controls for treatment; 2) systematic and specific comparisons of treatments, problems, and clients; 3) factorial designs to look at effects of treatment, age, and their interaction; 4) developmental approaches; 5) multiple assessment of pre- and post-therapy behavior; and 6) evaluation of outcome for the referred patient. She concludes, "If treatment of psychopathology in children is to gain a sound empirical foundation, better outcome research is imperative."

Comment: This article offers a good review of the shortcomings of empirical studies on treatment outcomes for children.

Evaluation

*Patterson, G.R., Chamberlain, P. & Reid, J.B. (1982). A comparative evaluation of parent-training program. *Behavior Therapy*, *13*, 638-650.

Synopsis: The authors report on an evaluation of parent-training procedures for families of preadolescent children who are antisocial.

The study described in this article compared a group of parents who received parent training to a waiting-list control group. The cases were screened to identify socially aggressive children who were observed to be highly coercive with other family members. After meeting the screening criteria, cases were randomly assigned to either the treatment or control group. Nineteen families were involved -- ten in the treatment group and nine in the waiting-list control group. All but one family in the control group chose to receive alternative treatment available in the community. The type of treatment used by control group families was mixed; three families were treated using an eclectic approach, two using behavior modification, one with an Adlerian approach, one with a structural family systems approach, and one with a combination of relaxation and exercise.

The experimental group was treated by trained staff at the Oregon Social Learning Center. Each family was seen individually in weekly sessions; the average treatment time was seventeen hours. Both the groups were observed in the home pre- and post-treatment -- six times during baseline and three times at termination. Parents were interviewed both pre- and post-treatment concerning their assessment of the occurrence (or nonoccurrence) of behaviors.

The results of an analysis of the observational data indicated a 17 percent reduction in deviant behavior from baseline to termination in the control group and a 63 percent reduction in the parent-training group. With respect to the parent report data, 90 percent of the parents in the treatment group reported that the intervention was "very effective" compared to 25 percent of the families in the control group. These results are interesting in that most outcome studies of the effectiveness of parent training programs have not shown a significant reduction in the observed deviant child behavior for the experimental group. The authors feel that their success is attributable to the fact that their program is not time limited and that their therapists (trainers) are well trained to deal with issues other than just child management, such as client resistance, marital conflict, and family crises.

Comment: This article was not intended to describe the techniques of the training but rather to present the impressive results of a structured and controlled evaluation.

*Tittler, B.I., Friedman, S., Blotcky, A.D. & Stedrak, J. (1982). The influence of family variables on an ecologically-based treatment program for emotionally disturbed children. *American Journal of Orthopsychiatry*, *52*(1), 123-130.

Synopsis: This article is a description of an ecological intervention program with family involvement.

The authors define an ecological approach as one which views emotional disability as a "manifestation of the current functioning level of the surrounding environment." The goal of the intervention is "the facilitation of sufficient adjustment and coordination in the relevant environmental systems to ease the individuals in distress." The approach described here is based on the ReED model which involves educational and therapeutic elements with children and their families as well as linking activities with community resources. The authors studied a residential treatment facility in Nashville, Tennessee, which combines structured milieu and educational experiences while integrating the family in treatment.

The authors predicted that the outcome of the ecological intervention would be related to the initial functioning level of the family, the initial engagement of the family in the intervention, and the continuing participation of the family. Outcome was determined by the child's academic functioning, the child's overall adjustment, and the family's level of functioning at the end of the program.

Eighteen children and their families were recruited over an eighteen-month period--fourteen males and four females ranging in age from six to sixteen (mean = 11.1 years). The children had neither psychotic behaviors nor retardation; they had moderate to serious degrees of behavior and learning disorders. Of the eighteen families, six were intact and twelve were one-parent families.

Data to measure level of family functioning were collected within two weeks of the child's enrollment in the residential program. The researchers measured distance in the mother-child relationship, contact with the environment, environmental stress, initial parent cooperativeness, overall parent contact with the facility, and progress in family counseling.

Results of the analysis revealed that the outcome variables of family functioning at the end of the program and child's overall adjustment were related to initial family functioning, initial engagement of the family, and continuing participation of the family. There was not as strong a relationship with the child's academic performance. The authors state that the "practical implications of this study concern the way in which the family is viewed when treating disturbance in children...Unless the family undergoes modification or accommodates to changes in the child, it is not likely that the child can sustain progress." Another experiental finding is that older siblings and other relatives can produce satisfactory results when parents are physically or emotionally unavailable.

Comment: The authors emphasize the importance of the involvement of family members in the treatment of children with emotional disabilities.

Evaluation

*Waldron, J.A. & Nurius, P.S. (1984). Assessment of behavioral change in a child psychiatric inpatient program. *Child Psychiatry and Human Development*, *15*(2), 121-32.

Synopsis: This article is a description of a study designed to determine whether positive change occurs during child psychiatric hospitalization.

Clinical observation tends to support the assumption that positive change occurs during hospitalization but there have been very few studies conducted to support this notion. The authors maintain that, "Research which focuses on the effectiveness of such treatment interventions is essential because of the risk of emotional trauma by the very separation of young children from their families and because of the high cost of inpatient psychiatric treatment."

The study was conducted in a twelve-bed psychiatric treatment unit for children between the ages of four and twelve. The unit was located in a large state hospital and served as a training site for a department of psychiatry, schools of social work, nursing, special education, and occupational therapy. The researchers explored behavioral changes made by the children during hospitalization and after discharge. The Devereaux Child Behavior Scale (DCBS) was the instrument selected because it was developed in a residential treatment facility similar to the one in this study, and the scale had been used with 252 children who had emotional disorders ages five to thirteen and on a "normal" sample of 348 public school children ages five to twelve. It was felt that these two samples could serve as comparison groups.

Data were collected from unit staff two weeks after admission and again at discharge and from parents prior to hospitalization and at three and six months post discharge. The fifty-five children ranged in age from five to thirteen, 80 percent were male, 56 percent were white, the reason for hospitalization was most often related to a severe behavioral disorder with a diagnosis of personality disorder, and the average length of stay in the hospital was 3.9 months (range two weeks to ten months).

Both parents and staff ratings indicated behavioral improvement, although parents rated their children having more disturbed behaviors than the unit staff did. The Devereaux Scale can be broken down into 17 behavioral areas which were analyzed separately. Both staff and parents indicated that there was significant change in the areas of *distractibility*, *ability to delay frustration*, and *social aggression*. The authors contend that because most of these children were referred because of impulsive, antisocial, and negativistic behaviors and the treatment program is strongly structured and closely supervised, these positive change scores are to be expected. Areas that did not show statistically significant change scores as rated by unit staff were *anxious fearful ideation*, *impulse ideation*, and *proneness to emotional upset*. The authors theorize that the duration of in-patient treatment is not long enough to affect these internal emotional areas.

The authors conclude that the unit's areas of strength are in assisting children achieve emotional connectedness and control of impulsive and aggressive behavior. Their weaknesses are in assisting children in developing self-care skills and in achieving behavioral and emotional autonomy.

Comment: The use of inpatient hospitalization is effective when the strengths of the treatment program fit the behavioral problems of the child.

THEORY

Apter, S.J. (1980, April). *International perspectives on ecological approaches to seriously emotionally disturbed children: Toward the development of a systems-oriented resource teacher model.* Paper presented at the Council for Exceptional Children National Conference on Seriously Emotionally Disturbed Children, Minneapolis, MN (ERIC Document Reproduction Service No. 201 101).

Synopsis: This paper is a discussion of programming strategies for children with serious emotional problems from an ecological or systems point of view.

Apter sees a problem in school-based service delivery systems for children who are labeled as having a serious emotional disorder. In this paper he focuses on the development of an ecological model for use in the classroom with this population of children. Ecologists believe that the interaction between internal and external forces accounts for behavior. Some major assumptions concerning ecological approaches to working with these children are: 1) each child is an inseparable part of a small social system; 2) disability is viewed as a lack of balance in the system; 3) discordance is a disparity between the ability of an individual and the expectations of the environment; 4) the goal of intervention is to make the system work (ultimately without the intervention); 5) improvement in any part of the system can benefit the entire system; and 6) the three major areas for intervention are the child, the environment, and attitudes and expectations.

Ecological interventions have the goal of improving the fit between the behavior and the setting. Specific procedures differ depending on whether the intervention is aimed at changing the child or the perception of the child's behavior, and the techniques of the intervener. One example of an ecological approach to working with children with disorders is Project Re-ED developed by Hobbs and his associates which involved home, school, neighborhood, and community. Another program is the Bridge Family Advocate which taught problem-solving skills to identify the source of difficulty and focused on the coordination of services.

Apter spent some time in Scandinavia studying their programs for children with emotional disabilities. One of the unique features of their system is a single contact person who coordinates all aspects of the family's needed services. Another positive feature of the Scandinavian system is an active prevention program (day care, sports centers, etc.). Overall, the society is more child-centered than in the United States, which leads to less family stress and more value placed on children.

The author applies his concepts of an ecologically oriented program for children with emotional problems to the role of a resource teacher. This person provides direct services to children as well as assists other adults who work with these children. The resource teacher can develop an understanding of the variety of elements in each child's system and can effect planned changes in those systems.

Comment: This article is very environmentally focused. The audience is those in the educational system.

Barker, P. (1982). Residential treatment for disturbed children: Its place in the '80's. *Canadian Journal of Psychiatry*, 27, 634-639.

Synopsis: This article is a discussion of the place and value of residential treatment for children who have emotional disabilities.

The author feels that treatment in a residential setting should only be used as part of a wider therapeutic plan. Removing a child from home to a residential setting is a drastic step, because it implies that the center can do better than the family, school, and community; it restricts the child's freedom; and it brings the child into contact with other youngsters who are troubled.

There are three main reasons children are in residential treatment: 1) to protect the community; 2) for their own protection; and 3) to obtain some specific therapeutic benefit. Children who are in residential treatment to protect the community fall into two groups--dangerous children and those who are a nuisance or embarrassment. The dangerous group (murderers, those with homicidal tendencies, rapists, and fire-setters) will probably continue to be placed in residential settings. The nuisance group, a much larger number, are questionable for this type of placement. One should ask if this is beneficial for the child, does it work, and what could work better.

Placement to protect the child is usually because the child is suicidal, a victim of physical or sexual abuse, runs away and gets in dangerous situations, or seriously abuses drugs or alcohol. For suicidal children, residential settings may be the best alternative. All the others in this group need help of some sort, but it should be questioned if this help can be obtained only in a residential setting.

The last group is referred to residential treatment because someone thinks it offers some special benefit. Some claim the following advantages for residential treatment: 1) it is the most intensive form of treatment; 2) it provides a therapeutic milieu; 3) it separates children from unfavorable families, schools, or neighborhoods; and 4) it tends to "legitimize the child's problems as being manifestations of 'sickness' (especially if the unit is in a hospital), or at least of a disorder of some sort, rather than just pure 'badness.' It may thus relieve guilt on the part of all concerned."

The author states, "Perhaps the question of whether the treatment is more intense depends upon what it is you want to treat intensively. If it is the child, then this may be so, but it if is the family, it is probably not." Barker feels it is generally best to work with families and other systems to bring about change than to work primarily with the children to change them. Exceptions could be children who have been seriously deprived of parental care and show this in their personality development. If the reason for placement is to separate the child from an unfavorable environment, then it is best to change the environment.

The author concludes, "We must distinguish between residential *treatment* and residential *placement*. .. [Placement] is really incidental to treatment. Residential treatment, as a therapeutic modality in its own right, is a different matter."

Comment: This article is a thought-provoking look at an issue that is becoming increasingly controversial.

Gaynor, J. & Hatcher, C. (1987). *The psychology of child firesetting.* New York: Brunner/Mazel.

Synopsis: This book is a description of firesetting behaviors, the pathology associated with them, and the approaches to treatment when working with children who set fires.

Fire setting behaviors range from accidental to intentional to criminal. Levels of behavior can be conceived as a continuum from fire interest to fire risk. There are numerous theories about the etiology of firesetting behaviors. From these various theories, the authors have extrapolated specific psychosocial determinants to predict youthful fire behavior. These are three major classes of determinants -- individual characteristics, social circumstances, and environmental conditions. Individual characteristics include demographics, physical, cognitive, emotional, motivation, and psychiatric. Social circumstances include the family, peers, and school. Environmental conditions are antecedent stressors, behavioral expression, and consequences. The predictive model developed by Gaynor and Hatcher has three major applications: 1) a framework for organizing knowledge; 2) generation of hypotheses that can be empirically evaluated; and 3) a clinical description, diagnosis, and treatment of children involved in pathological firesetting.

In almost all cases of pathological firesetting, there is no useful purpose for the fire. The five most common reasons for pathological firesetting are malicious mischief with accompanying antisocial behaviors, watching objects burn, feelings of revenge and anger, profit or earnings, and a malicious desire to destroy property or harm animals or people. The authors relate these to the determinants mentioned earlier. They state, "The exact mechanism of how these three critical elements of individual characteristics, social circumstances and environmental conditions interact to produce patterns of pathological firesetting is not yet understood. Nor is it clear why the described psychopathology leads to firesetting behavior as opposed to other antisocial, acting-out behaviors."

The authors feel that the most accurate description of firesetters is in the diagnosis of conduct disorder. They assert that the behavior of firesetting is relatively easy to eliminate but does not usually occur as an isolated behavior. The initial interviews and assessment are crucial to determining the history of the firesetting behavior and to identify targeted behaviors that must be changed. Inpatient therapy is recommended only if youngsters are a significant danger to themselves or others and severe psychopathology is indicated. The two most effective inpatient approaches are psychodynamic and behavior therapy. The three predominant outpatient therapies are cognitive-emotional, behavioral, and family psychotherapy. All three are effective in eliminating pathological firesetting and in improving accompanying behaviors. However, there are few empirical studies to support clinical evidence of success. The book ends with a model of community intervention strategies to educate, prevent and intervene.

Comment: This book is readable and it offers practical strategies to identifying and working with youngsters who set fires and their families.

McCauley, R. (1985). Alternative school programming for behavior disordered children. *Research In Education*, March (ERIC Document Reproduction Service No. ED 249 670).

Synopsis: The author focuses on the role of alternative schools for students who have behavioral disorders or serious emotional disabilities.

McCauley reviews the history and rationales of alternative schools for students who have behavioral disorders. He feels that these alternatives are often developed for the convenience of the school systems rather than for the well-being of students. It is often easier to start an alternative program than to modify a school's practices to fit student needs. It is necessary that a school system has well-defined guidelines for identification, referral, assessment, and placement-into-program procedures that guarantee a parent's (and child's) rights and "attempts to use objective and performance-level behavior as a basis for what are, in the final analysis, value decisions on how to best educate a child."

Once a child is placed in an alternative school, it is necessary that certain elements are in place, which include individualized instruction, goal-oriented learning, low student-adult ratios, clear rewards, flexibility, and caring and trained teachers. Curricula should be parallel to that of the regular systems in that they focus on generalized skills and innovative ways to influence learning. At the same time, it is important to blend in expectations of the mainstream program.

Issues related to socialization processes need to be carefully considered. Regardless of the philosophical or treatment focus a program chooses to follow, there are some features that contribute to the value of the alternative school program. A student progress system is correlated with pro-social role development. The program should be continually assessed and student behaviors observed in order to plan more precisely for a child. The author feels that the use of aversive or deprivational procedures should be severely restricted. If they are to be used in an alternative program, he recommends fourteen guidelines that should be followed.

The alternative school should plan for the transfer of behavioral progress from one environment to another. In order to mainstream a student to a general educational environment, there should be a transition procedure to facilitate this return. This planning process should be incorporated into the plans made for children at referral to the alternative school, and continued after they have entered the alternative program. It is necessary to study the responsibility of other environments in which the child resides and the lack of fit between the child and those environments. The general education system needs to be informed of the child's needs so it can determine how to modify their programming upon the child's return. Parents need to be included in the transition process.

Evaluations of alternative schools are difficult because of the variability in purpose, goals, and practices. It is also difficult to determine what to evaluate. Yet McCauley believes that evaluations should be conducted, if for no other reason than to assist the staff in formulating objectives and revising or modifying program components.

Comment: This article is a critical look at alternative schools with suggestions for making them a viable alternative for children with behavioral disorders. McCauley has a strong environmental modification focus.

Moos, R.H. & Fuhr, R. (1982). The clinical use of social-ecological concepts: The case of an adolescent girl. *American Journal of Orthopsychiatry, 52*(1), 111-122.

Synopsis: This article is a description of the use of semistructured interviews and structured questionnaires to conceptualize influences of the environment on a fifteen-year old girl.

The authors discuss the recent shift from person-oriented assessment procedures to a consideration of social-ecological factors and their relationships to individual mood and behavior. The hypothesis is that combining Bronfenbrenner conceptualization of a social-ecological system with Social Climate Scales (a focus on family, work, and social group settings, educational, psychiatric, and correctional milieus) can provide clinicians with information to formulate intervention strategies. Bronfenbrenner identified four components of a social-ecological system: 1) microsystem (interpersonal relationships, goal-directed activities and roles and role expectations in settings such as school or family); 2) mesosystem (interrelationships between two or more microsystems); 3) exosystem (settings where an individual is not an active participant but which can affect an individual's setting such as parents' work settings on family environment); and 4) macrosystem (cultural consistencies in the other three systems, social values and beliefs).

By administering the Social Climate Scales to a child and her parents, the authors addressed four questions: 1) How can information about the social settings in which a client participates (the microsystem) help to formulate a clinical case description, identify problem areas, and suggest intervention strategies? 2) How can data on client perceptions of ideal settings facilitate this process? 3) How can the dynamic interrelationships between the settings in which people participate, such as school and family or family and work (the mesosystem) affect their morale and well being? and 4) How can a setting in which an individual does not participate directly (the exosystem) influence the development of a problem that appears to be primarily intrapersonal?

The last part of this article describes the use of this technique with a fifteen-year old girl and her family. The girl dropped out of school and was moody and depressed. The results of the ecological assessments were shared with the family who then participated in family therapy. As a result of the work with this family the authors conclude, "Such knowledge should help clinicians to overcome the attributional error of underestimating the relative importance of environmental as compared to dispositional determinants of behavior."

Comment: This article has applicability to Therapeutic Case Advocacy because of the emphasis on ecological assessment.

Theory

Palmer, A.J., Harper, G. & Rivinus, T.M. (1983). The "adoption process" in the inpatient treatment of children and adolescents. *Journal of the American Academy of Child Psychiatry*, *22*(3), 286-293.

Synopsis: This paper is an exploration of the process in inpatient settings whereby staff behave as if they are a child's parents.

The authors describe the "adoption process" as a phenomena that occurs when staff of treatment facilities assume a parental role to the exclusion of children's parents or legal guardians. The adoption process influences the staff, the parents, and the child. In staff, the process manifests itself in the ways they view the case, in the treatment plan, and behavior toward the child and the parents. The child often rejects the parents and seduces the staff into an inappropriate role. Parents quietly abdicate their parental function which is viewed by staff and the child as rejection and abandonment. The adoption process develops a circular pattern.

The process could begin at any time but usually starts with treatment planning. Staff leave parents out of the assessment and treatment planning. Reasons for this vary from viewing the parents as inadequate to inadvertent oversight. Staff tend to "adopt" children as parents drift away. Thus special treatment of selected children disrupts the treatment plan and teamwork. The child assumes a special place in the life of the staff member who views himself or herself as a rescuer. Discharge planning with an "adopted" child is often vague and ill-planned. The staff member inadvertently thwarts attempts to set specific target dates or goals. Often the message conveyed to the child is that there is no future after the hospital.

This process is a solution which tends to reduce everyone's anxieties. The authors state, "As such the actions inherent in the Adoption Process replace thoughtful discussion of troubling wishes, impulses, and fears." Hospital programs themselves contribute to the problem because of the placement of the child on the "inside" and the rest of the family on the "outside," restrictive visiting policies, and the wide array of services (group activities, arts and crafts, recreation) that many parents cannot offer.

There are numerous reasons for adoption process development. Clinicians are vulnerable to the process because of the positive motivations that led them to their careers, because of their altruism and empathy, because of their own developmental stages, and because of their past successes. Parents often feel relief (and guilt) when a child is hospitalized. They may feel overwhelmed by the competence and patience of the staff. Children themselves experience pain intensely and invite rescue. They often fantasize about having different or more "ideal" parents.

Because of the adoption process, treatment stagnates, the parents receive little help in coping, length of hospital stays are stronger, documentation is inadequate, discharge planning is inadequate, and more unnecessary out-of-home placements occur. Solutions are to select a family-oriented treatment approach in every phase of the process -- assessment, planning, and treatment. The authors conclude, "The words 'adoption' and 'adopt' have a shock value that arrests the attention of most clinicians, forcing them to consider (sometimes incorrectly but always usefully) the possibility that unconscious dismissal of the actual parent is occurring."

Comment: This article is thought-provoking and should be of interest to clinicians and parents alike.

Rutter, M. (1982). Psychological therapies in child psychiatry: Issues and prospects. *Psychological Medicine, 12*, 723-740.

Synopsis: The author reviews recent changes in the prevailing concepts concerning therapeutic strategies and tactics in the treatment of child psychiatric disorders.

Both family therapy and behavioral methods of treatment reflect changes in the concepts of child psychiatric disorders and views concerning the goals of treatment. Three concepts that have led to recent changes in child psychotherapies are that: the child's behavior should be viewed in its social context; the child is a thinking person who takes an active role in dealing with stress and problems; and the child is a developing organism.

Emphasis on therapeutic aims has changed. First, symptom reduction is a necessary, prime goal of treatment. Second, the promotion of normal development is also an essential goal. Third, autonomy and self-reliance need to be fostered so skills are acquired to deal with future problems. The fourth change is the appreciation of the importance of generalization of the improvements in the child's behaviors, emotions, and relationships. Fifth, it is important to determine whether treatment benefits remain over time. Lastly, there is an increased focus on changing the environment rather than directly changing the children themselves.

These changes in aims have lead to changes in therapeutic strategies and tactics. One strength of behavioral therapy is the large number of alternative strategies and tactics available. The repertoire of behavior therapy techniques continues to expand. Specific strategies and tactics of intervention are also expanding in psychodynamic psychotherapy, especially in family therapy. In addition to the variety of strategies, there is an emphasis on short-term, focused psychotherapies. There is also an increased awareness of the importance of therapist qualities. The use of residential settings is more selective and families are more actively involved. The author states, "...treatments that deal with the child in isolation from his usual environment have considerable limitations."

The author discusses the effectiveness of treatments and concludes that some psychological therapies influence children's maladaptive behaviors in beneficial ways. Some less effective treatments include long-term unfocused individual psychotherapies, psychodynamic therapies for delinquents, and individual insight therapy for young autistic children. Rutter does not feel we yet know which treatments are most effective for specific disorders or why specific therapies work with some children and not others. Many areas still need to be explored with better research.

Comment: This article by a British author, is an exploration of the subject of psychological therapies from a more global perspective than many others in the literature.

Schneider, S. (1980). A proposal for a network of psychiatric services for adolescents. *International Journal of Therapeutic Communities, 1*, 5-14.

Synopsis: This article is a description of a network of services for adolescents who have emotional problems.

This article is a discussion of a plan for a network of psychiatric services for adolescents in Israel. The author feels continuity of care for adolescents who have disorders is extremely important. "The *only* way to insure continuity of care, continuation with the same therapist, placement in a specific facility and individualized programming, is if one administrative body controls all the parts of the system." This model was developed at the Summit Institute in Jerusalem.

The modules of the network include an in-patient psychiatric hospital, a closed residential treatment center, an open residential treatment center, a half-way house ("nurturing" type), a half-way house ("high expectations" type), therapeutic communities, day care, outpatient treatment, and no treatment. Wherever treatment occurs, the network staff serves as the "centralized body coordinating treatment/education/vocation and recreation services." The Summit Institute's main building serves as the residential treatment center. Here there is an emphasis on the use of groups and milieu treatment as well as educational and vocational training.

The "high expectations" half-way house is for five to seven students who live together with one staff member. The emphasis is on independence and working or studying in the community. The next step is transitional homes or apartments without live-in staff. The emphasis is on total independence. The therapeutic community is established by the students with an outside staff member as a facilitator. The "nurturing" half-way house has a focus on more long-term care with more staff who have the primary responsibility for running the house. A student may begin here or end up here if other parts of the system are not helpful.

An essential part of the network is an educational/vocational center in a separate building that serves all parts of the network from residential to outpatient. Outpatient services are continued with the same therapist when the student has returned home, is in foster care, or is living independently.

The author feels that this model network of psychiatric services will speed up the reintegration of adolescents with emotional problems back into the community.

Comment: The author describes an interesting model based on a systems of care approach with all levels addressed by one agency and therapist or coordinator.

Schneider, S. (1985). The role of parents in the treatment of emotionally disturbed adolescents. *Family Therapy, 12*(1), 35-43.

Synopsis: This article is a discussion of the role of the family in the treatment of adolescents with emotional problems including issues such as the necessity of family therapy, adolescent rights to privacy and confidentiality, and who is the client.

Schneider presents the various theories and positions regarding parental involvement in mental health treatment for adolescents. These views range from the position that the family is always the focus of treatment to the view that the therapeutic relationship between the adolescent and the therapist is an exclusive one. Most positions fall somewhere between these two extremes. It is evident from the literature that the question of the extent of parental involvement is unresolved.

The author's work in residential treatment facilities has led him to develop certain guidelines to determine the degree of parental involvement. He feels that the following issues need to be explored. 1) *Age.* If the adolescent is over 15 years old, an adolescent-oriented treatment plan is more readily accepted. 2) *Separation.* Whether the problem is adolescent-centered (identity, rebellion, acting out) or family-centered (pathological symbiosis) will determine degree of parental involvement. 3) *Identified Patient.* Questions such as, is the adolescent shipped out to stabilize the family? Is the problem a symptom of the family system? Are therapists over-identifying with the adolescent? 4) *Therapeutic Alliance.* Do therapists develop a relationship with adolescents at the expense of parents? How do therapists keep from alientating parents? 5) *Contract.* Deciding not to treat parents is part of a treatment plan. Ground rules need to be established early in the treatment process. 6) *Developmental Lines.* The developmental stage of the adolescent is the major determinant of the extent of family involvement.

The author's preference is, "We rarely treat *only* the family system. Our psychodynamically oriented approach centers on the adolescent, but includes the family when necessary." This means that adolescents have their own therapists. If family therapy is part of the plan, another therapist is used, or rarely co-therapists (one is the child's) only if the child agrees. When parents communicate with the child's therapist, they are told that all information will be shared with the adolescent and the same holds true for information from the therapist to parents. The adolescent's privacy is protected and confidentiality maintained.

The author concludes that, "In residential treatment, the adolescent, not the parent, is our client. However, contact is maintained with the parents, and they are encouraged to participate when it would help the therapeutic process."

Comment: This author tends to view the child (rather than the family) as the client; the rationale for this bias is strongly related to the developmental level of the adolescent.

Theory

Schoenfeld, P. (1988). Network therapy: Natural social support for young adults with mental disorders. *Tie Lines*, *5*(1), 1-3.

Synopsis: The author addresses network therapy from the perspective of the young adult. Similar techniques could be employed with adolescents.

Schoenfeld defines a social network as, "...that group of people who have an actual or potential role in providing help and support to a person in time of stress as well as in the usual business of everyday life." Mental health professionals have begun to look at the importance of a social network; helping a patient develop a support system is a major goal of psychosocial rehabilitation. Goals of networking as a treatment intervention are educational, pragmatic, systemic, and preventative.

The educational component includes providing information to those in the social network and exploring views and attitudes of network members toward mental illness. Education helps alleviate fears and concerns of others toward the patient and family.

Pragmatic interventions empower the network members to become actively involved with the family. A goal of network therapy is to provide guidelines for helpful involvement such as finding appropriate work settings, help with transportation, social activities, and other everyday needs.

Network therapy involves understanding the effects on the family of having a member with an emotional disorder. The systemic intervention can "infuse new energy and hope into the overburdened, often isolated family system. System members can offer objective observations, support, and influence."

As a preventative intervention, convening a family's social network makes it possible to identify strengths, weaknesses, and resources.

Network therapy has developed slowly because of, among other things, the large numbers of people involved and the actual process of conducting meetings. Schoenfeld describes a project he conducted in the Holyoke/Chicopee Area Office of the Department of Mental Health in Massachusetts. The purpose of the demonstration project was to see how network therapy could be used with persons leaving a hospital and as a means of preventing hospitalization. Two studies conducted to evaluate the project indicate that network therapy is extremely promising as an intervention. The network meetings were helpful to case managers, service providers, parents, network members, and the patient.

Comment: Even though the author addresses the needs of young adults and their families, the philosophy and techniques are applicable to other age populations and their families.

Vander Ven, K. (1982). **Puzzling children:** A challenge to the child care service system. *Journal of Children in Contemporary Society, 14*(4), 5-12.

Synopsis: This article is a description of puzzling children and issues related to their treatment.

Puzzling children are those who lie in the "gray area of ambiguity" between normality and exceptionality. Because impairments are not obvious and there are not clearly identified treatments, these children are a challenge to the service delivery system. Critical issues are: parent-professional relationships; theoretical concepts of etiology and professional discipline; assessment and diagnosis; clinician characteristics; and treatment trends.

The relationship between parents and professionals is crucial, because parents are usually the first to suspect that something is wrong with their child. They must then consult a professional who may or may not confirm their fears, who may or may not listen and be sensitive to parental concerns, and who may or may not blame them for the puzzling behavior of their child.

Two theoretical issues germane to the puzzling child are concepts of causation and theoretical backgrounds of practitioners. The linear model of cause and effect needs to be replaced by an interactional approach whereby children are studied from multiple perspectives. In the same vein, one should be aware of the relationship between professional discipline and actual practice.

Even though a diagnostic and assessment process needs to occur with puzzling children, this process should be approached carefully and with flexibility. Experienced clinicians generally have the breadth of knowledge to grasp the multiple variables involved with these children who have complex and subtle difficulties.

Child treatment trends should be taken into account but not overemphasized to the exclusion of other perspectives and approaches. Two recent trends--family therapy and early intervention--have their weaknesses as well as strengths. In family therapy, variables contributed by the child can be ignored and thus go untreated. Early intervention can lead to stigmatizing labels and some inappropriate interventions. The important issue is to ensure that assessment is accurate with each individual child.

Comment: The author presents a good overview of the issues and concerns when dealing with children with problematic behaviors.

Whittaker, J. (1979). *Caring for Troubled Children.* San Francisco: Jossey-Bass.

Synopsis: Whittaker looks at residential care and the place this type of treatment should hold with other elements in the continuum of services for troubled children.

The author takes an ecological perspective on treatment services for children with emotional problems. In Whittaker's view, "ecological theory looks at the interaction between organisms and their environments." The concept of residential treatment can be expanded to include the environments to which the child will return after placement. A special emphasis is placed on the family and the school.

Whittaker presents five guidelines in planning for services. 1) One goal should be to develop a continuum of care with a full range of home-based and residential options and establish links between the various service programs and the other major systems in which the child participates such as family, peer group, school, church, and community. 2) Residential and day programs should function as a family support system rather than treating the child in isolation. 3) Residential and day treatment programs should focus on growth and development in the child's total life rather than on curing syndromes or correcting problematic behaviors. 4) No single theory or practice will answer the needs of a program that is geared to the total range of children's development and is oriented to their total ecology. 5) Children's residential and day treatment programs should be able to explain what they do in simple, clear, and jargon-free terms.

Although Whittaker does not promote any one treatment approach over another, he sets forth some essential elements of a therapeutic milieu in a residential setting. These include a small size, involvement in the community, flexibility, and understandability to the public. The milieu could include rules, routines, program activities, groups, individual psychotherapy, life-space interviews, incentive system, special education, conjoint family therapy, parent education groups, parent involvement in life space, and individual behavior modification programs.

The major approaches to residential treatment are presented, including psychoanalytic, behavioral, guided group interaction, and education approaches. Whittaker feels that each approach has furthered knowledge of the therapeutic milieu and that no model of treatment should be based solely on theoretical presuppositions but on the real-life problems of the children. The author suggests that the major components of a planned group living environment are an incentive system, program activities, and a group intervention system. Each component includes a teaching relationship between the child and the worker where the focus is on basic social, emotional, and cognitive skills.

The gains made in the residential setting must be maintained when the child returns to school, family, and neighborhood. This requires an investment in rigorous community follow-up. Involving parents as full and equal partners in the helping process is of paramount importance in this process. Ways to involve parents include family support groups, parent education, parent involvement in the "life space" (the day-to-day program), and conjoint family treatment. All of these should be sensitive to cultural differences and based on the real-life environments of the families.

Comment: Whittaker explores many of the concepts involved in Therapeutic Case Advocacy including an ecologically-oriented continuum of services, a family as partner focus, and environmental fits based on strengths in the child and family.

OTHER

Other

*Chassin, L., Young, R.D. & Light, R. (1980). Evaluations of treatment techniques by delinquent and disturbed adolescents. *Journal of Clinical Child Psychology*, 9(3), 220-223.

Synopsis: This article offers a comparison of evaluations of treatment approaches between adolescents who are delinquent and those who have emotional disorders.

In studies with adults it is clear that client expectations and perceptions concerning psychotherapy are important to the success of treatment. The authors feel that the same is true for adolescents. Previous research on evaluation of treatment indicates that there are differences between adolescents who are referred for emotional problems and those who are deemed delinquent. The authors state, "The current study attempted to determine whether or not these previously reported differences in treatment evaluations were an artifact of varying research methodologies or were a reflection of differences in adolescent client populations."

The youth involved in this study were fifty-five male adolescents who were in a correctional facility and thirty-three male and female adolescents who were inpatients in a psychiatric hospital. The delinquent group were of a lower socioeconomic status and included more minorities. All the adolescents completed a questionnaire rating sixty-five treatment techniques; they also participated in a brief structured interview concerning their own treatment experiences.

Results of the study indicated that some treatment techniques were rated highly by both groups. These included a "desire for a worker to be both concerned and interested in the adolescent child, but at the same time to be firm and limit-setting as well." Those who were delinquent preferred a warm, firm relationship with the therapist and concrete assistance. The adolescents who were hospitalized preferred a more traditional and limited therapeutic relationship that explored personal feelings and insights. Both groups rated "manipulative friendship" factors lowest. This involved violations of trust, lack of authenticity, and attempts to act as a peer.

The differences between the two groups could be related to socioeconomic status, symptomatology, and experience with particular agencies. The authors suggest that careful consideration of an adolescent's perceptions is important in planning treatment. The similarities of the two groups is also important because they transcend issues of specific therapies.

Comment: The authors point to the importance of matching perceptions and expectations with treatment strategies when working with adolescent populations.

Other

Harris, L.H. (1981). Goal attainment scaling in the treatment of adolescents. *Social Work in Education, 4*(1), 7-18.

Synopsis: The article is a description of the use of goal attainment scaling by school social workers in the treatment of students with disabilities and the development of Individualized Educational Plans (IEPs).

This article discusses a project in a Minnesota public school district involving school social workers, special educators, and adolescents who have emotional disorders. The program called SAIL (Student Advocates Inspire Learning) used goal attainment scaling to fulfill IEP requirements and to intervene effectively with students. Goal attainment scaling features various techniques that: 1) provide an individualized approach to treatment and outcome measurement; 2) allow for negotiated goals and objectives; 3) focus on explicit issues; 4) set realistic expectations; 5) build accountability; and 6) ensure consistent program structure and feedback.

Goal attainment scaling is a method of setting goals on a five-point scale from the worst possible outcome to the best possible outcome. The emphasis is on the middle level (expected outcome) which encourages students to set realistic and attainable goals. The SAIL staff help each student select between six and fifteen individualized goals related to such areas as classroom attendance, academic achievement, aggression, alcohol or drug abuse, sexuality, peer and family relationships and irresponsibility.

A goal attainment guide includes four sections: 1) names of student and goal setters; 2) goal setting date and follow-up scoring date; 3) scales themselves in columns across the top of the page; and 4) the five levels with the center level set off with double horizontal lines as the expected level of outcome. The initial goal setting session takes about 45 minutes; subsequent sessions usually take about a half an hour. First time students are followed-up after four weeks, but students who are familiar with the system usually have a follow-up at the end of a term or semester.

Even though students have similar problems, each goal should be individualized and expressed in terms the students understand. The middle level of outcome is developed first with all levels expressed in specific behaviors and time limits. The student reviews the completed guide to determine if it is realistic. The guide becomes part of the IEP, a copy is given to parents, and the SAIL staff keep a copy for weekly scoring which occurs at a meeting with staff and student. Each level is assigned a weighted score ranging from -2 through +2 with 0 being the expected level.

A list of guidelines developed by SAIL staff include: 1) develop at least four scales for each student; 2) have at least three levels completed for each scale (one has to be the middle or "expected" level); 3) no expected level should be too high to allow for "more than expected" levels or too low to allow "less than expected" levels; 4) emphasize weekly scoring to give students continuous feedback; 5) be sure all goals are verifiable; 6) expect resistance but overcome it by insisting that students select and write goals; 7) teach students to share progress with their parents; 8) do not automatically raise expectations once levels are reached; 9) use group goal attainment to build cohesiveness in a program; and 10) select one staff member to review and supervise goal-writing procedures with the rest of the staff.

Comment: This article was written for special educators of children with emotional handicaps.

Other

Lask, J. & B. Lask (1981). *Child Psychiatry and Social Work.* London: Tavistock Publications.

Synopsis: The authors offer basic knowledge of child problems, a framework for understanding causes, and methods of intervention.

The authors advocate a broad-based eclectic approach to treatment of children with problems. They also feel that the family is the first resource for understanding the child's difficulties, and whenever possible, the family should be the client rather than just the child. Social work's contribution to helping a child who has an emotional disorder is to view all interactions between the child, family and environment as possible targets for intervention.

The authors maintain that psychosocial development is affected by a variety of factors including biological and genetic influences and socio-cultural experiences. They add that the interaction of these various factors is equally important in any attempt to determine cause of emotional problems. The authors maintain "...that family therapy is potentially the most effective way of helping children and adults with behavioral and emotional problems, and that it warrants detailed consideration by all social workers."

This book includes discussions of individual and group therapies and their effectiveness. Because of their admitted bias, the authors feel these should be used when family therapy is not possible or in conjunction with family therapy. The book includes a chapter on behavior modification techniques thought to be effective in the treatment of enuresis, fears and phobias, school phobia, antisocial and behavior problems, and problems of adolescence.

The authors maintain that social workers need to explore ways of working with other professionals, "for no profession can hope to encompass all the knowledge and skills necessary to help children and families with problems."

Comment: This book presents a good overview of interventions with children with emotional problems; it is clear, however, that the authors feel that family therapy is always an intervention of choice.

Other

*Lewis, W.W. (1982). Ecological factors in successful residential treatment. *Behavioral Disorders*, *7*(3), 149-56.

Synopsis: This article is a report on a review of follow-up studies of children who had been in residential treatment and on a pilot study of former students of a center that is committed to ecological planning.

The author states that a review of follow-up studies reveals that type or amount of improvement during treatment is not related to adjustment on follow-up. One exception is Project Re-ED where improved school achievement scores were predictive of later good adjustment. In fact, from the review of follow-up studies, Lewis suggests, "...ecological factors may be more important than improvement during treatment in shaping later adjustment." A supportive environment is essential following treatment.

A study was conducted of former students of Cumberland House, one of Project Re-ED's model schools. All children selected for the study had done well in treatment. After six months, half had been successful in community adjustment and half had serious problem behaviors after discharge. No significant difference existed between the two groups regarding age on admission, sex, IQ, race, or length of stay in treatment. Data on each child's ecological circumstances during treatment were obtained from files. Two types of data were extracted from each child's record: 1) a general rating of the amount of support or stress provided by each major person in the child's ecosystem on admission and at graduation, and 2) the number and quality of contacts recorded for each participant in the child's ecosystem while in treatment. The results of the study indicated that the children who were adjusting well on follow-up had greater support within the family and from community agencies and schools during their enrollment in the Cumberland program. The ecosystems of the two groups were similar at admission to the program. In addition, the "successful" children had continuing help after discharge from community agencies and/or schools. Parental communication was more frequent and positive for the successful group at discharge. Size and complexity of a child's ecosystem seemed to have no bearing on outcome.

Lewis concludes, "...ecological support is essential to maintaining personal gains made by children during residential treatment."

Comment: The findings of the studies reported in this article support the underlying principles of Therapeutic Case Advocacy.

Other

*Simons, R.L. & Miller, M.G. (1987). Adolescent depression: Assessing the impact of negative cognitions and socio-environmental problems. *Social Work, 32*(4), 326-330.

Synopsis: The authors report on a study of more than 400 high school students. One negative condition--low evaluation of self--and two socio-environmental variables were related to adolescent depression.

This study examined socio-environmental problems and negative beliefs to help explain the etiology of adolescent depression. The socio-environmental factors were: 1) lack of parental support; 2) interpersonal difficulties at school; and 3) employment problems. The cognitive variables included: 1) attitudes about self; 2) alienation and feelings of powerlessness; and 3) perceptions of future educational and occupational opportunities.

A questionnaire was administered to 423 midwest high school students -- 255 males and 168 females. The questionnaire included two hundred close-ended items related to youth problems, difficulties, and needs and measured attitudes, feelings, and behavior. The analysis included a path analysis that provided an estimate of the effects of the variables on depression. Self-esteem was the only significant cognitive variable. Of the socio-environmental variables, low parental support had a moderate statistically significant relationship to depression while employment problems had a smaller, but still statistically significant relationship.

The authors suggest that the results of this study indicate that cognitive factors of adult depression play a lesser role in adolescent depression. They also suggest that treatment of adolescents with clinical depression should include working on socio-environmental factors, especially family support and employment. Simons and Miller conclude: ". . . clinicians delivering services to depressed adolescents also should consider the need for family therapy and counseling in employment matters. Cognitive strategies might modify the adolescent's negative self-perceptions, but such interventions likely will be ineffective if they are not supplemented by procedures that address the socio-environmental problems maintaining the low self-evaluations."

Comment: This article is of interest because of its attention to socio-environmental factors in relation to affective disorders.

Other

*Wilner, D.M., Freeman, H.E., Surber, M. & Goldstein, M.S. (1985). Success in mental health treatment interventions: A review of 211 random assigned studies. *Journal of Social Service Research*, *8*(4), 1-21.

Synopsis: This article is a report on 211 mental health outcome evaluations that used random assignment of clients to treatment groups.

Over the past thirty years, there have been numerous efforts to evaluate the efficacy of mental health interventions. There have been reviews of these studies with mixed critical results. One of the latest and best known studies was conducted by research staff at the University of Colorado, which concludes that mental health interventions have "a powerful and consistent positive impact."

The authors of this article aimed to evaluate the success of evaluations of outcome in the field of mental health. They chose to focus on "high quality" evaluations which they defined as being reported on in one of fifty major journals, and utilizing randomly selected control groups of more than twenty subjects. Using these criteria for research conducted between 1969 and 1979, 211 studies were identified.

Of the 211 studies, about one-third dealt with psychotic patients, about one fifth with adult personality and adjustment problems, and about one-fifth were concerned with children (divided into school-related disorders and behavior and adjustment problems). Approximately 40 percent of the studies were concerned with behavioral reinforcement, around 20 percent employed some form of psychotherapy, 13 percent dealt with aftercare treatment, and 10 percent used some variety of milieu therapy. Two-fifths of the studies used criteria of both psychological and behavioral attributes in judging patient outcomes. Of the remaining three-fifths, behavioral measures outnumbered psychological measurement two to one. Principal behavioral measures were: 1) discharge or readmission to institutions; 2) school or employment performance; 3) social and interpersonal behavior; 4) personal behavior and addictive behavior. Principal psychological measures were 1) judgments of clinical and emotional states, and 2) personality tests, indexes, and scales.

The authors of this article assessed the "success" of the interventions by using the language of the authors of the studies as a guide along with a common sense notion of what mental health professionals mean by the term "success." One third of the studies reported only success, one-fourth were entirely without success, and the remainder were mixed. Interventions dealing with alcohol and drug abuse and with psychoses showed the least success. The most successful treatment methods were reinforcement conditioning, psychotherapy, and a combination of the two; the least successful were milieu treatment and electroshock. The authors conclude that one initial aim in their review of the research was to discover what treatments work best for particular problems, and that this was not possible because of the complexity of the studies.

Comment: This article, in some much more rigorous ways, presents an attempt to discover what we all are attempting to learn--what interventions seem to work and for whom.

Other

*Winsberg, B., Bialer, I., Kupietz, S., Botti, E. & Balka, E.B. (1980). Home vs. hospital care of children with behavior disorders. *Archives of General Psychiatry, 37*(4), 413-418.

Synopsis: This article is a description of a study to compare treatment outcomes of community and hospital programs for children with behavior disorders.

The study described here compared outcomes of a community program which emphasized social services and pharmacotherapy with a typical hospital treatment program (Kings County Hospital in Brooklyn). The two programs were evaluated with respect to 1) behavioral change, 2) educational progress, and 3) changes in maternal psychiatric symptoms and role functioning and in-family adjustment. The children all had severe behavior disorders, were of both genders, and ranged in age from five to thirteen years. All children were admitted for inpatient psychiatric treatment at Kings County Hospital, all had at least one natural parent or parent surrogate at home who was willing to accept either treatment. Most of the children had a history of chronic severe behavior problems with serious school problems and had received outpatient psychiatric treatment. After admission to the hospital, pre-treatment data were collected and evaluated. Children then were randomly assigned to either the community or hospital programs.

The community program was staffed with two caseworkers, a child psychiatrist, and a psychiatric nurse. Treatment emphasized active recruitment of social services for the family and parental support. Traditional psychotherapy was not provided but referrals were made to a community mental health clinic if it was deemed necessary. Pharmacotherapy consisted of prescribing "the least toxic psychostimulants first and then progressing through the more toxic tricyclic and neuroleptic compounds." The distinguishing features of the community program were constant availability of staff, persistent advocacy, and treatment flexibility.

The ward at the hospital was supervised by a child psychiatrist, a psychologist and a mental health nurse. Children received a combination of individually designed treatments including pharmacotherapy, psychotherapy, and milieu therapy. The family treatment consisted of social casework, counseling, and psychotherapy. Education was provided by a hospital school under the direction of the New York City Board of Education.

Outcome measures revealed that the community group improved in the areas of aggressivity, inattentiveness, and hyperactivity, whereas the hospital group improved only in inattentiveness. Educationally, both groups progressed in reading and arithmetic. On the parent and family variables there were no significant pre- and post-test differences or between group differences. Follow-up data obtained one and one half to three years after the termination of this study revealed that of the twenty-four hospital group children, eleven were in institutional settings. Of the 25 community-care group children, eighteen were living at home. Most of the forty-nine children continue to have severe behavioral disabilities. Despite the less than spectacular outcomes for children in either program, the authors conclude "...children for whom extended inpatient treatment was recommended could be maintained in the community with special care and intervention."

Comment: Because the purpose of this study was to compare hospital and community programs, the article does not provide great detail on the specifics of treatment interventions.

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